

SUPERVISOR'S REPORT OF WORK INJURY

*****Attach this form to the "Employers' Report of Occupational Injury or Illness" (Form 5020)*****
and mail to CFSA's Workers' Compensation Claims Administrator

SECTION I. EMPLOYER INFORMATION AND IDENTIFICATION

FAIR NAME:

ADDRESS:

CITY:

STATE:

ZIP:

TELEPHONE NUMBER:

SECTION II. EMPLOYEE INFORMATION

Did Employee: Stay on Job Go Home See Physician Hospitalize Other Return to Restricted Work

First Name: _____ M. I. ____ Last Name: _____ Social Security No. _____

Employee's Usual Occupation: _____ Occupation at Time of Accident (If different) _____

Nature of Injury/Illness: _____ Part of Body: _____ Object Involved: _____

Person(s) in Control of Object: _____ First Aid Given by: _____ Attending Physician: _____

Hospital/Address/Phone: _____

EMPLOYEE CATEGORY:

Regular Full Time

119 Day

Temporary Part Time

Other (Describe) _____

Length of Employment: _____ Days/Mo/Yrs

Time in Occupation at Time of Injury: _____ Days/Months/Years

SECTION III. ACCIDENT DESCRIPTION

LOCATION OF ACCIDENT:

DATE & TIME OF INJURY/ILLNESS: _____, _____:_____ AM PM

Was an employee injured in the accident? Yes No

Did the incident involve employee illness? Yes No

Did the incident involve property damage? Yes No

Was a motor vehicle involved? Yes No

(If yes, attach copy of "driver's report of accident")

Clearly Describe What Happened:

WITNESSES AND OTHER INJURED, ILL OR INVOLVED:

Name: _____ Phone #: _____

Name: _____ Phone #: _____

Name: _____ Phone #: _____

Name: _____ Phone #: _____

SEE REVERSE SIDE OF FORM FOR SECTION IV.

SECTION IV. SUPERVISOR/MANAGER ACCIDENT ANALYSIS

LOSS SEVERITY POTENTIAL:

- Minimal Moderate
 Low Severe

PROBABLE OCCURRENCE RATE:

- Negligible Moderate
 Low High

COST OF CONTROL:

- Minor Medium
 Low High

DEGREE OF CONTROL ACHIEVED:

- None Moderate
 Low Complete

DID INJURED EMPLOYEE RECEIVE PRIOR TRAINING IN TASK? YES NO

CONTRIBUTING CAUSES OF ACCIDENT:

RECOMMENDATIONS FOR PREVENTION OF RECURRENCE:

HAS, OR WILL THIS ACCIDENT BE REVIEWED IN EMPLOYEE SAFETY MEETINGS? YES NO

IF THIS ACCIDENT MEETS IMMEDIATE REPORTING GUIDELINES TO CAL/OSHA, HAS NOTIFICATION TAKEN PLACE? YES NO

Supervisor: _____

Date: _____

Manager: _____

Date: _____