Charles Drew University  
Supervisor’s Report of Work-Related Injury/Illness/Exposure/Near Miss  
UNDER NO CIRCUMSTANCES IS THE INJURED EMPLOYEE TO COMPLETE THIS FORM

### EMPLOYEE INFORMATION

<table>
<thead>
<tr>
<th>Name:</th>
<th>Employee ID#:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Address:</td>
<td>Home Telephone:</td>
</tr>
<tr>
<td>City/State/Zip:</td>
<td>Sex:</td>
</tr>
<tr>
<td>Department:</td>
<td>Department Telephone:</td>
</tr>
<tr>
<td>Department Head:</td>
<td>Supervisor:</td>
</tr>
</tbody>
</table>

### EMPLOYEE INFORMATION

Employee usually works: No. of days per week: No. of hours per day: No of hours per week:  
Work Schedule: _____ AM ☐ PM ☐ to _____ AM ☐ PM ☐ Shift Work: Yes ☐ No ☐

### EVENT INFORMATION

<table>
<thead>
<tr>
<th>Date of Incident:</th>
<th>Lost Time? Yes ☐ No ☐</th>
<th>*Dr’s note required – Send to HR</th>
</tr>
</thead>
<tbody>
<tr>
<td>Time of Incident:</td>
<td>*Complete the following only if time is lost: Date last worked:</td>
<td>Was another person responsible for the Incident? Yes ☐ No ☐</td>
</tr>
<tr>
<td>AM PM</td>
<td></td>
<td>Other workers injured? Yes ☐ No ☐</td>
</tr>
<tr>
<td>If employee died, date of death:</td>
<td>Still off of Work? Yes ☐ No ☐</td>
<td>Witnesses? Yes ☐ No ☐</td>
</tr>
<tr>
<td>Your date of knowledge of event:</td>
<td>Date returned to work:</td>
<td>Date claim form provided to employee:</td>
</tr>
</tbody>
</table>

Specific injury/illness and part(s) of body affected: (i.e., broken finger on right hand, tendonitis in left elbow, etc.)

What was the employee doing when the incident occurred? (i.e., loading boxes on truck; cleaning classroom, etc.)

What chemicals, equipment, etc., was employee using when the event occurred?

Did the incident occur on the Employer’s premises? Yes ☐ No ☐  
Location/Department where the incident occurred:

Was the affected person acting in the line of duty? Yes ☐ No ☐

Describe how the incident occurred (if more space is needed, place attach separate sheet of paper):

What steps should be taken to prevent a similar accident/event?

### MEDICAL INFORMATION

Check the appropriate box(es):

☐ No Medical Treatment – Accident/Exposure/Near Miss Report Only  
☐ Medical Treatment Received at: St. Francis Medical Center  
☐ Other – Please complete the follow information:

<table>
<thead>
<tr>
<th>Physician Name:</th>
<th>Address:</th>
<th>Phone</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>City/State/Zip:</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

If hospitalized, please complete:

<table>
<thead>
<tr>
<th>Facility Name:</th>
<th>Address:</th>
<th>Phone</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>City/State/Zip:</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Charles Drew University
Supervisor’s Report of Work-Related Injury/Illness/Exposure/Near Miss
PLEASE COMPLETE PARTS A&B FOR EVERY INJURY/ILLNESS
AND PART C ONLY IF THERE ARE WITNESSES

Employee Name: ____________________________  Employee ID: ____________________________
Date of Injury/Illness: ____________________________  Date Returned to Work: ____________________________
What type of work did employee return to:  Regular [ ]  Modified [ ]

A. MODIFIED WORK – Please check appropriate box(es):

If injured employ is unable to perform full duties, but may return to work on temporary limited duties, is modified work available or can an alternate work assignment be provided?

☐ Temporary modified duties are available –or–
☐ Alternate work assignment available (work other than regular assigned job duties).
☐ No return-to-work plan developed. Request assistance from Human Resources.

If unable to provide modified duties or alternative work assignment, please list reasons:

____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________

B. VERIFICATION – Please check one of the following:

☐ I verify that the injury/illness of this claim is work-related.
☐ I am unable to determine if this injury is caused by current employment.
☐ A physician’s report will be necessary to verify if injury/illness is related to employee’s current employment at CDU.
☐ The facts do not indicate that this claim of injury is work-related. Please investigate.

Please provide below, reasons to support why you believe this claim may not be work-related.

____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________

C. WITNESSES: (To be completed only if answering yes to “Witnesses” quested on Page 1)

List name(s) of Witnesses:
____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________

COMPLETED BY:

Name: ____________________________  Title: ____________________________
Signature: ____________________________  Date: ____________________________

Risk Management Comments:
____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________

Completing this form is not an admission of liability.

Signature: ____________________________  Date: ____________________________