Chabot-Las Positas Community College District
5020 Franklin Drive
Pleasanton, CA 94588

Supervisor's Report of Employee Injury

EMPLOYEE INFORMATION

Name ☐ Mr ☐ Ms		SSN or W#:	Age:
Home Address (Street) (City) (Zip Code)			Home Phone ( ) -
Job Title	Employee Class Code: (Check One) ☐ Classified ☐ Certificated ☐ Administrative		Date of Hire / /
Employee's Regular Work Location: ☐ CC ☐ LPC ☐ District	Employee Usually Works ____ Hours a Day ____ Days a Week = _____ Total Weekly Hours		Employment Status: (Check One) ☐ Full Time ☐ Part Time ☐ Temporary

INCIDENT INFORMATION

DATE OF INJURY: / /	Time of Injury: ________ AM ☐ PM ☐	Time Employee Began Work: ________ AM ☐ PM ☐	Unable to Work for at least one full day after date of injury? ☐ Yes ☐ No
Date Last worked: / /	Date Returned to Work: / /	Is Employee still off work? ☐ Yes ☐ No	Date of Employer's knowledge/notice of Injury: / /
Date Employee was provided claim form: / /	Injury Location: ☐ CC ☐ LPC ☐ District Office Location on Campus/Building where Accident Occurred:		
Specific Activity the Employee was performing when the event occurred:			
Describe: (1) how the injury occurred (2) any objects/material that caused the injury and (3) all specific body parts affected:			
Names of any Witnesses:			
Did Employee Report to a Physician? ☐ Yes ☐ No		Was this at an Emergency Room? ☐ Yes ☐ No	
Physician Name:		Physician Phone ( ) -	
Physician Address:			
Did Employee go home for the remainder of the day? ☐ Yes ☐ No		Did Employee require Hospitalization? ☐ Yes ☐ No	

SUPERVISOR'S EVALUATION

What specific steps have been taken to prevent similar accidents from occurring?

______________________	( ) -	/ /
Supervisor's Signature	Office Phone Number	Date

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