MT. SAN ANTONIO COLLEGE MANAGERS REPORT OF EMPLOYEE INJURY/INCIDENT

1100 North Grand Avenue
Walnut, CA 91789-1399
909.274.7500 • www.mtsac.edu

IMPORTANT: This form is to be completed by the employee's manager to **investigate**
And provide information concerning the injury and immediately submitted (within one business day)
To workcomp@mtsac.edu, you can also contact the HR Work Comp Analyst at ext. 5501.

Name of Injured:_____ Job Title: _____

Department: _____ Extension: _____

Home Address: _____ Telephone: _____
Number, Street

_____ Date of Hire: _____
City, State, Zip

Date of Accident:_____ Hour:_____ AM/PM (please circle)

Date Employer First Knew of Accident:_____Reported to: _____

Accident Location _____
(Be specific-building, parking lot, etc. If location not on campus, please include address)

_____

What was employee doing at time of injury?: _____
(example: loading trucks, emptying trash, etc.)

_____

How did accident/illness/exposure occur? _____

Employee Work Hours:

Hours Per Day_____ Days Per Week_____ Total Weekly Hours _____

Shift hours:_____A.M./P.M. to_____ AM/PM (please circle)

Employee status – check one

- ☐ Regular Full-Time
- ☐ Regular Part-Time
- ☐ Hourly as Needed
- ☐ Student Worker
- ☐ Clinical
- ☐ Volunteer

Apparent nature of injury – Briefly describe: _____
(Example: cut, sprain/strain, etc.)

Injured part of body (please check):

- ☐ Head
- ☐ Finger L/R Digit
- ☐ Arm L/R
- ☐ Abdomen
- ☐ Neck
- ☐ Eye L/R
- ☐ Leg L/R
- ☐ Hand L/R
- ☐ Back
- ☐ Chest
- ☐ Face
- ☐ Foot L/R

Did Injury Involve Sharps (Needles)?	☐ Yes	☐ No

Was 911 called? ☐ Yes ☐ No

Name of witness(es) and phone numbers/extensions _____

Was personal protective equipment required? (protective glasses, safety shoes, safety hats, etc.) Was injured employee using required equipment properly? _____

Corrective action taken (modification of a machine, environment, training, etc.) _____

Additional comments _____

COMPLETED BY:

Signature _____ Date _____

Printed name _____ Extension _____

APPROVED BY:

Signature _____ Date _____

Printed name _____ Extension _____

Please have employee complete section below before returning form to workcomp@mtsac.edu:

Employee Description of Accident: _____

_____

_____

_____

Does employee wish to seek medical attention? ☐ Yes ☐ No

If yes, where? (name and address of facility or hospital) _____

COMPLETED BY EMPLOYEE:

Signature _____ Date _____

Printed name _____ Extension _____

HR Work Comp Use Only:

EE ID Number: _____

Salary/ Pay: _____

Confirmed Date of Hire: _____

12/2024:HR/as