



# 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

<b>Did Injury Involve Sharps (Needles)?</b>	<input type="checkbox"/> Yes	<input type="checkbox"/> No
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Was 911 called?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
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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 \_\_\_\_\_  
Printed name \_\_\_\_\_

Date \_\_\_\_\_  
Extension \_\_\_\_\_

**APPROVED BY:**  
Signature \_\_\_\_\_  
Printed name \_\_\_\_\_

Date \_\_\_\_\_  
Extension \_\_\_\_\_

**Please have employee complete section below before returning form to [workcomp@mtsac.edu](mailto:workcomp@mtsac.edu):**

Employee Description of Accident: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

<b>Does employee wish to seek medical attention?</b>	<input type="checkbox"/> Yes	<input type="checkbox"/> No
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If yes, where? (name and address of facility or hospital) \_\_\_\_\_

**COMPLETED BY EMPLOYEE:**  
Signature \_\_\_\_\_  
Printed name \_\_\_\_\_

Date \_\_\_\_\_  
Extension \_\_\_\_\_

**HR Work Comp Use Only:**  
EE ID Number: \_\_\_\_\_  
Salary/ Pay: \_\_\_\_\_  
Confirmed Date of Hire: \_\_\_\_\_

12/2024:HR/as