



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 employee's manager to investigate
And provide information concerning this injury and immediately submitted (within one business day)
To Risk Management, Building 4-Room 2555

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 Hourly Worker
[] Clinical [] Volunteer

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

Injured part of body (please check):
[] Neck [] Eye L/R [] Leg L/R [] Hand L/R [] Head [] Back [] Finger L/R Digit [] Chest [] Arm L/R [] Face [] Abdomen [] Foot L/R

Did Injury Involve Sharps (Needles)?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
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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 before returning form to Risk Management:

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 _____

Risk Management Use Only:

Salary Rate _____
Comments _____
Incident Only _____

4/2018:rm/sv