CALIFORNIA STATE UNIVERSITY, LONG BEACH
ACCIDENT INVESTIGATION REPORT

Information contained on this form is for official use only, for the exclusive benefit of the CSULB

INVESTIGATION: TO BE COMPLETED BY SUPERVISOR

AFFECTED EMPLOYEE NAME (LAST, FIRST, MI)	JOB TITLE	DATE OF INJURY	TIME OF INJURY
DEPARTMENT/DIVISION	**PHONE/EXT**	**DATE REPORTED**	**TIME REPORTED**

Location: [ ] **On-Site** [ ] **Off-Site Overtime Involved?** [ ] Yes [ ] No
Address and/or worksite description:

Injury / Illness / Incident Body Part(s) Affected:

Please check box if reporting near miss only (no property damage or bodily injury involved).

DESCRIBE SEQUENCE OF EVENTS (Specify activity, policy or procedure performed prior to incident. *Use additional sheets as needed)*

HOW DID THE INJURY / ILLNESS / INCIDENT OCCUR? (Please include any Safety Policy and Procedures that were not followed. *Use additional sheets as needed*):

WITNESSES: [ ] Yes [ ] No (attach dated and signed "Witness Statement" form; page two of this document)

PHOTOS: [ ] Yes [ ] No (attach dated and signed "Witness Statement" form; page two of this document)

Did the accident occur during the course of normal assigned duties? [ ] Yes [ ] No	Was this injury/illness/ incident caused by unsafe work environment or equipment malfunction? [ ] Yes [ ] No (If yes, explain and attach photos)

I do not wish to file a Workers' Compensation Claim form or seek medical treatment at this time. I understand I am not waiving my right to file a claim. Per LC (5405) an employee has 1 year from the date of injury to file a Workers' Compensation Claim Form.

Employee Signature: ______________________________ ____________________
Date

All Statements in the above section are true and correct to the best of my knowledge and belief. Completed by:

Supervisor Name (print):	Signature:	Date/Time:

Department Manager Name Review and Approval: (print)	Signature:	Date/Time:

This form shall be completed and send to the Workers' Compensation Coordinator within 24 hours of the incident. For questions please call (562)985-2366.

CALIFORNIA STATE UNIVERSITY, LONG BEACH
WITNESS STATEMENT FORM

To be completed by incident witness:

Information about the person making this statement: (Please print or write clearly.)

First name ______________________________ Last name ____

Job title ___________________________ Department______________________ Division _____________________

Department Manager ________________________ Department Supervisor ________________________________

Describe exactly what you observed, regarding this incident. (Use additional sheets if needed)

Date of Injury / Illness _________________Time of incident __________________________________AM / PM

Location of incident ____

Other witnesses ____

Statement ____

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All Statements in the above sections are true and correct to the best of my knowledge and belief. Completed by:

________________________________	________________________________
Witness signature	**Date/Time**

Box below to be completed by Dept./Div. representative:

Statement received by (print name and signature) ______________________________

Date/time statement received ____