California State University, Long Beach

SUPERVISOR'S ACCIDENT INVESTIGATION REPORT

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

INVESTIGATION: TO BE COMPLETED BY SUPERVISOR			
AFFECTED EMPLOYEE NAME: (LAST, FIRST, MI)	JOB TITLE	DATE OF INJURY	TIME OF INJURY
EMPLOYEE ID	SCHEDULED WORK HOURS	EMPLOYEE CLASSIFICATION	
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:	

SUPERVISOR REVIEW					
Facts available lead me to believe this work injury was caused by and happened during State Work.	☐	From the facts I need my supervisor's or a physician's advice. The alleged claim of injury is not clearly identified with State employment.	☐	The facts do not indicate this claim of injury was work connected.	☐
Details of Injury/Accident (who, what, where, when, etc.): (Attach Additional Pages, If Necessary)					
Corrective Action Recommended:					
Witness(es): ☐ Yes ☐ No (attach dated and signed "Witness Statement" form; page two of this document					
Photo(s): ☐ Yes ☐ No (attach copies)					

Employee Name (print):	**Signature:**	**Date/Time:**
All Statements in the above sections are true and correct to the best of my knowledge and belief. Completed by: **Supervisor Name (print):**	**Signature:**	**Date/Time:**
Do you concur with the first line of Supervisor Review? ☐ Yes ☐ No If No; explain:		
Department Manager Name Review and Approval **(print):**	**Signature:**	**Date/Time:**

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

California State University, Long Beach

SUPERVISOR'S ACCIDENT INVESTIGATION REPORT

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

WITNESS STATEMENT FORM: to be completed by incident witness

Information about the person making the statement:

First Name	Last Name	
Job Title	Department	Division
Department Manager	Department Supervisor	

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

Date of Injury/Illness	Time of Incident ☐ AM ☐ PM

Location of Incident:

Other Witnesses:

Statement:

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

Witness Name (print): **Signature:** **Date/Time:**

Box Below to be Completed by Department/Division Representative:

Statement received by (Print Name): **Signature:** **Date/Time:**

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