SUPERVISOR'S REPORT OF WORK INJURY

***** Attach this form to the "Employers' Report of Occupational Injury or Illness" (Form 5020)***** and mail to CFSA's Workers' Compensation Claims Administrator

SECTION I. EMPLOYER INFORMATION AND IDENTIFICATION		
FAIR NAME:		
ADDRESS:		
CITY:		
TELEPHONE NUMBER: ()		
SECTION II. EMPLOYEE INFORMATION		
Did Employee: □Stay on Job □Go Home □See Physician □Hospitalize □Other □ Return to Restricted Work		
First Name: Init Last Name: Social Security		
NO.		
Employee's Usual Occupation: Occupation at Time of Accident (If		
different)		
Nature of Injury/Illness: Part of Body: Object		
Involved:		
Person(s) in Control of Object: First Aid Given by: Attending		
Physician		
Hospital/Address/Phone:		
EMPLOYEE CATEGORY:		
☐ Regular Full Time ☐ 119 Day ☐ Temporary Part Time		
□ Other (Describe)		
Length of Employment: Days/Mo/Yrs Time in Occupation at Time of Injury: Days/Months/Years		
Section III. Accident Description		
Section III. Accident Description Location of		
Location of		
Location of		
Location of Accident:		
Location of Accident:		
Location of Accident: DATE & TIME OF INJURY/ILLNESS: PM		
Location of Accident:		
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Location of Accident:		

SUPERVISOR'S REPORT OF WORK INJURY Page 2 WITNESSSES AND OTHER INJURED, ILL OR INVOLVED: Name:_____ Phone Name:_____ Phone #:_____ Name:_____ Phone Name:_____ Phone #:_____ SEE REVERSE SIDE OF FORM FOR SECTION IV. **SUPERVISOR/MANAGER ACCIDENT ANALYSIS** SECTION IV. LOSS SEVERITY POTENTIAL: PROBABLE OCCURRENCE RATE: ☐ Minimal ☐ Moderate □ Negligible □ Moderate \Box Low □Severe \Box Low ☐ High COST OF CONTROL: **DEGREE OF CONTROL ACHIEVED:** ☐ Minor ☐ Medium \square Moderate □None Low □High \Box Low □ Complete DID INJURED EMPLOYEE RECEIVE PRIOR TRAINING IN TASK?.....□YES □NO CONTRIBUTING CAUSES OF ACCIDENT:

RECOMMENDATIONS FOR PREVENTION OF RECURRENCE:_	:	

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HAS, OR WILL THIS ACCIDENT BE REVIEVED IN EMPLOYEE SAFETY MEETINGS?	□YES □NO
IF THIS ACCIDENT MEETS IMMEDIATE REPORTING GUIDELINES TO CAL/OSHA, HAS NOTI	IFICATION
TAKEN PLACE?	□YES □NO
Supervisor:	Date:
Manager:	Date: