CLAREMONT McKENNA COLLEGE

Supervisor's Report
of Occupational Injury or Illness

Must be submitted within 24 hours of occurrence.
Human Resources will complete COVID-19 claims.

1. Employee's Name: _____ 2. Job Title: _____
3. Date of Injury/Illness: _____ 4. Date & Time Reported: _____ at _____ ☐ AM ☐ PM
5. Location of Injury/Illness (e.g., building & room): _____
6. Will the employee be paid their full scheduled shift for the date of the injury/illness? ☐ Yes ☐ No
7. Describe in detail what the employee was doing, how it was being done, and any tools, people, and/or machines involved. If possible, give details such as object weight(s), temperature(s), chemical(s), or any other relevant factors.

_____

_____

_____

_____

_____

8. Was the employee doing something other than their required work duty at the time of the injury? ☐ Yes* ☐ No
   * If yes, please describe below what, why, and directed by whom:

_____

_____

_____

9. Do you question the validity of this claim? ☐ Yes* ☐ No
   * If yes, please describe below the reason (e.g., witnesses, prior conversations, personal issues, and/or suspicion).

_____

_____

10. What caused the injury/illness to occur? (Select all that apply)

- ☐ Improper or defective equipment/machinery
- ☐ Location (poor layout or lighting)
- ☐ Lack of skill, training, or experience
- ☐ Lack of personal protective equipment
- ☐ Adequate skill but failure to execute/follow directions
- ☐ Inadequate safeguards; unsafe job design
- ☐ Housekeeping, clutter, spillage, breakage
- ☐ Material handling
- ☐ Poor ergonomics in workstation design
- ☐ Other: _____

11. What can be done to prevent such an accident from happening again?

_____

_____

12. Who will assume responsibility to ensure #11 is completed? _____
13. By when will #11 be completed? _____

Supervisor Name: _____ Contact Phone Number: _____

Supervisor Title: _____ Department: _____

Supervisor's Signature: _____ Date: _____

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