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California State University Chico
Human Resources Service Center
EMPLOYEE LEAVES & WORKERS COMPENSATION

400 W. 1ST STREET
KENDALL HALL ROOM 213
CHICO, CA 95929-0010
530-898-4670
FAX: 530-898-4364

Work Related Injury and Illness Incident Report (OSHA 301 Form)

ATTENTION: This form contains information related to employee health and must be used in a manner that protects the confidentiality of employees to the extent possible while the information is being used for occupational safety and health purposes.

SUPERVISOR INSTRUCTIONS

1. Immediately complete and provide the employee with the ***MEDICAL TREATMENT INFORMATION FOR WORK RELATED INJURY/ ILLNESS FORM*** (see last page).
2. Report the illness/injury immediately to Employee Leaves and Workers' Compensation, (530) 898-4670.
3. The employee's direct supervisor (and the area administrator) must promptly **complete ALL sections of the OSHA 301 form**. (Under no circumstances is the injured/ill employee to complete this form)
4. Immediately Fax the OSHA 301 Form to Employee Leaves and Workers' Compensation, fax (530) 898-4364.

I. INJURED/ILL EMPLOYEE

Name _____ Job Title _____

Street Address _____ Work days: ☐ Mon ☐ Tues ☐ Wed ☐ Thu ☐ Fri ☐ Sat ☐ Su

City _____ State _____ Zip _____ Work Schedule: _____ ☐ AM ☐ PM to _____ ☐ AM ☐ PM

Home Phone Number _____ Usually works # _____ hrs/day / # _____ days/week / # _____ hrs/wk

Work Phone Number _____ Department Abbreviation: _____ Phone _____

CSUC Employee ID # _____ Direct Supervisor: _____ Phone _____

Gender: ☐ Male ☐ Female ☐ Nonbinary Area Administrator: _____ Phone _____

II. FACTS RELATED TO WORK-RELATED INJURY/ILLNESS

Date/time of injury or onset of illness _____ at ___:___ ☐ AM ☐ PM

Date/time employee began work _____ at ___:___ ☐ AM ☐ PM

Date of supervisor's knowledge or notice of injury illness _____

Any witnesses? ☐ Yes* ☐ No

*Witness Name(s): Phone Number

_____ _____

_____ _____

What was employee doing just before the incident occurred? *(Describe the activity, as well as the tools, equipment, or material the injured employee was using. Be specific. Examples: "climbing a ladder while carrying roofing materials"; "spraying chlorine from hand sprayer", daily computer key-entry", etc.)*

What happened? *(Tell us how the injury occurred. Examples: "When the ladder slipped on the wet floor, worker fell 20 feet"; "Worker was sprayed with chlorine when gasket broke during replacement"; "worker developed soreness of right wrist over time", etc.)*

What was the injury or illness? *(Tell us the part of the body that was affected and hot it was affected; be more specific than "hurt", "pain" or "sore." Examples "strained lower back"; "chemical burn to left hand"; "carpal tunnel syndrome of right hand.")*

What object or substance directly harmed the injured employee? *(Examples: "concrete floor; "chlorine"; "radial arm saw". If this question does not apply to the incident, leave it blank.)*

Did injury/illness occur on employer's premises? ☐ Yes ☐ No Location/building where injury/illness occurred:

_____

III. MEDICAL TREATMENT (EMPLOYEES RECEIVING MEDICAL TREATMENT MAY NOT RETURN TO WORK WITHOUT A MEDICAL RELEASE)

☐ **TREATED SELF** *(No medical treatment sought)*

☐ **DESIGNATED MEDICAL FACILITY**

☐ **Enloe Medical Center Emergency Services**
1531 Esplanade, Chico, CA 95926
Phone: (530)332-7300
Hours: Always Open

☐ **Work Health Solutions**
565 Rio Lindo Avenue Suite 201, Chico, CA 95926
Phone: (530)715-8004
Hours: Monday-Friday, 8am - 5pm

How was injured/ill employee transported to medical facility?

☐ Ambulance

☐ Other _____

IV. LOST WORK TIME (AN ABSENCE NOT SUPPORTED BY A SIGNED PHYSICIAN'S STATEMENT IS NOT COVERED BY WORKERS' COMPENSATION BENEFITS.)

A. Did the employee lose work time (other than on the first day of injury/illness or date of initial medical evaluation) due to this work-related injury/illness?
☐ Yes ☐ No (If "Yes", please complete B and C)

B. Date/time employee first began to lose work time _____ at ___:___ ☐ AM ☐ PM

C. Is employee still off work due to this work-related injury? ☐ Yes ☐ No

D. The employee returned to work _____ at ___:___ ☐ AM ☐ PM
(REMINDER: EMPLOYEES RECEIVING MEDICAL TREATMENT MAY NOT RETURN TO WORK WITHOUT A MEDICAL RELEASE)

V. DEPARTMENTAL REVIEW In our opinion (check one):

☐ Facts available indicate that this injury/illness is work-related and occurred during the course of the employee's usual and customary work hours and duties.

☐ It is unclear from the available facts known as to whether this injury/illness is work-related. Additional information may be necessary to make a determination.

☐ The facts available do not indicate that this injury/illness is work-related.

OSHA 301 COMPLETED BY: (Direct Supervisor or Area Administrator)

Supervisor Name	Signature	Title	Date

Supervisor Name	Signature	Title	Date

California State University Chico
Human Resources
Service Center
EMPLOYEE LEAVES & WORKERS COMPENSATION

400 W. 1ST STREET
KENDALL HALL ROOM 213
CHICO, CA 95929-0010
530-898-4670
FAX: 530-898-4364

Medical Treatment Information for Work-Related Injury/Illness

SUPERVISOR INSTRUCTIONS: Please provide this completed form to your employee

EMPLOYEE: _____ POSITION: _____ EMPL ID# _____

DATE OF INJURY: _____ TIME OF INJURY: ___:___ ☐ AM ☐ PM

TYPE OF INJURY: _____

SUPERVISOR NAME: _____ SUPERVISOR PHONE: _____

SUPERVISOR SIGNATURE: _____ DATE: _____

EMPLOYER INFORMATION
California State University, Chico
Employee Leaves and Workers' Compensation
400 W. 1st Street
Chico, CA 95929-0010
Phone: 530-898-4570 / Fax: 530-898-4364

WORKERS' COMPENSATION TPA
(Self-Funded)
Sedgwick-CMS
PO Box 14629
Lexington, KY 40512-4529
Phone: 916-851-8024 / Fax: 916-851-8089

APPROVED MEDICAL FACILITIES:

For treatment of a serious* injury/illness or outside of COMP California Occupational Medical Professionals business hours.

COMP California Occupational Medical Professionals
505 Wall Street, Chico, CA 95928
Phone: (530)809-4907
Hours: Monday-Friday, 8am - 5pm

Work Health Solutions
565 Rio Lindo Avenue Suite 201, Chico, CA 95926
Phone: (530)715-8004
Hours: Monday-Friday, 8am - 5pm

Enloe Medical Center Emergency Services*
1531 Esplanade, Chico 95926
Phone: (530)332-7300
Hours: Always Open

**Injuries, which are considered serious include (but are not limited to): serious laceration; lumbar (back) strains; knee strains or dislocations; possible bone fractures; loss of consciousness or ambulation; life threatening injuries; and exposure to hazardous substances.*

EMPLOYEE INSTRUCTIONS:

After the initial medical evaluation and each subsequent follow-up visit, you will receive either a Work Status Form (PR-2) or written discharge instructions. It is your responsibility to forward a copy of this documents to Employee Leaves and Workers' Compensation immediately after the initial medical evaluation and after all follow-up visit(s). You may submit this document via fax# 530-898-4364) or you may hand-deliver it to the Employee Leaves and Workers' Compensation office at Kendall 213.

If you have any questions please call Employee Leaves and Workers' Compensation at (530)898-4670