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CALIFORNIA STATE UNIVERSITY CHICO
HUMAN RESOURCES SERVICE CENTER
BENEFITS & WORKERS' COMPENSATION

400 W. 1ST STREET
KENDALL HALL ROOM 220
CHICO, CA 95929-0010
530-898-5436
FAX: 530-898-5755

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. **REPORT THE ILLNESS/INJURY IMMEDIATELY TO BENEFITS & WORKERS' COMPENSATION UNIT, (530) 898-5436.**
2. **Within 8 hours of the injury or illness.**
   a. The employee's direct supervisor (and the area administrator) must complete ALL sections of the OSHA 301 Form.
   (Under no circumstances is the injured/ill employee to complete this form)
   b. Fax the OSHA 301 Form to the Benefits & Workers' Compensation Unit, fax (530) 898-5755

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/wk / # ____ hrs/wk

Work Phone Number _____ Department Abbreviation _____

CSUC Employee ID # _____ Dept Phone Number 898-_____

Gender: ☐ Male ☐ Female Direct Supervisor _____ Ext.____

Area Administrator _____ Ext.____

II. FACTS RELATED TO WORK-RELATED INJURY/ILLNESS

Date/time of injury or onset of illness _____ at ____ : ☐ AM ☐ PM Any witnesses? ☐ No ☐ Yes*

Date/time employee began work _____ at ____ : ☐ AM ☐ PM *Witness Name(s): Phone No.

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

If employee died, date/time of death _____ at ____ : ☐ AM ☐ PM _____ _____

Were other CSUC Employees injured? ☐ No ☐ Yes Was an outside agency/party responsible? ☐ No ☐ Yes

Specific injury/illness and part(s) affected: (i.e. broken finger on right hand; tendonitis in left elbow, etc.)

What was employee doing when event occurred? (i.e. loading boxes on truck; cleaning classroom; driving tractor, etc.)

What chemical, equipment, etc. was employee using when the event occurred?

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

Describe how injury/illness occurred :

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

A. Did the injured employee receive medical evaluation/treatment for this work-related injury/illness? ☐ No ☐ Yes
If answer is "YES", where did the employee receive the medical evaluation/treatment? *(Check appropriate box below)*

Designated Medical Facilities:

☐ CSUC STUDENT HEALTH SERVICES *(for minor injuries only)*

☐ ENLOE PROMPT CARE (BRUCE RD) *(for non-minor injuries or any injuries occurring after Student Health Services hours or on weekend)*

☐ ENLOE EMERGENCY ROOM *(life-threatening injury/illness requiring medical care before 8 a.m. or after 8 p.m.)*

WAS EMPLOYEE HOSPITALIZED OVERNIGHT? ☐ No ☐ Yes

Pre-Designated Personal Physician (Employee must have pre-designated own personal physician prior to injury.)

☐ No ☐ Yes (If answer is "YES", provide physician information below.)

Physician Name _____

Street Address _____

City _____ State ____ Zip _____

Phone _____ Fax _____

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

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

B. Date/time employee first begin 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

Please provide reasons below to support why you believe this claim may or may not be work-related:

If applicable, check one of the following:

☐ I am unable to determine if this injury is caused by current employment. A physician's report will be necessary to verify if the injury/illness is related to employee's current employment at CSU, Chico

☐ The facts to not indicate that this claim of injury is work-related. Please investigate.

Was the employee following safety procedures when injury occurred? ☐ Yes ☐ No

Describe corrective action that has been taken to prevent a reoccurrence:

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

Supervisor Name	Signature	Title	Date

OSHA 301 REVIEWED BY: (Area Administrator Only)

After discussing this incident with the employee's direct supervisor, I agree with his or her perception of the injury:

☐ Yes ☐ No - Please explain here:

Area Administrator Name	Signature	Title	Date