California College of the Arts
Department of Public Safety

INJURY REPORT FORM

Name of Injured:			**Date/time of Accident:**
❑ **Student Worker**	❑ **Faculty**	❑ **Staff**	❑ **Other**
Home Address:		**Phone (H):**	**Phone (W):**
What time did employee start work?		**Name of Supervisor:**	
Date of Birth:		**Department:**	
Hire Date:			
Date/time reported:		**Reported to:**	
Was first aid given? By whom?		**Was injured worker sent to clinic?**	
		Name of Medical Clinic:	
Identification of the Accident Factors			
Description of Accident/Injury:			
Physical Address and Location of Accident:			
Name/phone/address of Witnesses:			
(Please attach witnesses' statements to this report)			

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Victim's Statement of How Injury Occurred:	
Observations of Public Safety Officer/HR/Supervisor: (Identify act or condition that caused accident to happen. Explain why the act or condition existed. Identify any action taken to address this situation.)	
Any person who makes or causes to be made any knowingly false or fraudulent material statement or material representation for the purpose of obtaining or denying workers' compensation benefits or payments is guilty of a felony.	
Signature of Injured Worker:	**Signature of Public Safety Officer/HR/Supervisor:**
I decline medical treatment: (Signature of Injured Worker/date if applicable)	
Additional Information:	

Copies to: **Dean of Students (Student)**
Director of Human Resources (Staff & Faculty)
File