California State University, Long Beach
1250 Bellflower Boulevard
Long Beach, CA 90840

ACCIDENT INVESTIGATION REPORT

INJURED NAME: _____

DEPARTMENT: _____

COLLEGE/DIVISION: _____

DATE OF INJURY: _____

1. **Describe where injury happened and what part/s of the body were injured?**

2. **How did the accident happen? What caused the injury?**

3. **What corrective action has been taken?**

4. **What corrective action remains to be taken?**

5. **Did the accident occur during the course of normal assigned duties? ☐ YES ☐ NO**

6. **Name(s) of witnesses:**

Name:	_____	Name:	_____
Dept:	_____	Dept:	_____
Extension:	_____	Extension:	_____

Signature of Supervisor: _____ _____
Date

I do not wish to file a Workers' Compensation Claim form or seek medical treatment at this time. I understand I am not waiving my right to file a claim. Per LC (5405) an employee has 1 year from the date of injury to file a Workers' Compensation Claim Form.

Employees Signature: _____ _____
Date

This form shall be completed and sent to the Workers' Compensation Coordinator within 24 hours of the incident. For questions please call 562-985-2366.