



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

ACCIDENT INVESTIGATION REPORT

INJURED NAME: _____

DEPARTMENT: _____

COLLEGE/DIVISION: _____

DATE OF INJURY: _____

1. How did the injury occur?
2. Why did the accident happen?
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 Office of Safety, Risk Management and Information Security within 24 hours of the incident. For questions please call 562-985-2366 or 562-985-2283.