CALIFORNIA LUTHERAN UNIVERSITY
Injured Person's Statement

Name of Injured Person: _____ **Date of Injury:** _____

☐ Employee ☐ Student ☐ Guest

Time of Injury: _____ *am/pm* Injury Reported to: _____

Describe the sequence of events pertaining to the incident including: activity performed, tool/equipment, others in the area, personal protective equipment, location prior to the incident, actions taken during and following the incident, etc.: __

_____

_____

_____

_____

_____

_____

Location on campus where incident occurred: _____

Body part injured: _____

Witness(es): _____

Have you been given medical treatment for the injury: ☐ Yes ☐ No

Note: For a work related injury, please contact Human Resources to be directed to a designated treating physician and authorization form.

If yes, where? _____

If no, do you decline treatment at this time and why? _____

Have you previously filed a claim for or received other payments based on a disability or illness? ☐ Yes ☐ No

If yes, please explain: _____

_____

Could this injury/incident have been prevented? ☐ Yes ☐ No _____

Personal Information

Date of Hire (if employee): _____ EE ID # _____

Address: _____

Contact phone # _____ Date of Birth: _____

CLU supervisor: _____ Department: _____

I state the above is true and correct to the best of my knowledge.

_____ _____

Signature of Injured Person Date

For HR Office Use:

☐ DWC-1 provided ☐ Sent to designated physician/clinic ☐ Supervisor Statement Recvd: _____

☐ Reported to Travelers ☐ Pre-designation of physician on file ☐ Witness Statement