

STATE OF CALIFORNIA		EMPLOYEE WORK INJURY		Date of Report	
STD. 620		SUPERVISOR'S INJURY PREVENTION REPORT			
A. INJURED EMPLOYEE			B. MEDICAL TREATMENT		C. SUPERVISOR
Date of Injury		Time		First Aid Given By:	
Last Name		First	Middle	<input type="checkbox"/> Treated Self	
Home Address			Treated by (physician)		Department
City or Town		Social Security Number		Office Address	
Home Phone Number		Date of Birth		Supervisor's Office Mailing Address	
Classification			Telephone Number		Office Telephone Number
Place Injury Occurred (address)			Hospital		Signature

SUPERVISOR'S COMMENTS: (Use other side for more information, sketches, etc.)

1. Describe nature of injury and part of body affected as employee tells about it:

2a. Facts available lead me to believe this work injury was caused by and happened during State work.	2b. From the facts I need my superior's or a physician's advice. The alleged claim of injury is not clearly identified with State employment.	2c. The facts do not indicate this claim of injury was work connected.
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3. Give the facts that justify the items checked.

4. Did injury result in disability beyond day of accident? <input type="checkbox"/> YES <input type="checkbox"/> NO If "YES," give date last worked.	Has employee returned to work? <input type="checkbox"/> YES <input type="checkbox"/> NO Date returned.
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5. What was injured doing at time of injury? (Explain so people at your headquarters will understand)

6. Describe work place and conditions which contributed to the accident — also what safety devices were in use?

7. Fully explain sequence of events that resulted in injury (how did employee's actions and work conditions combined, cause injury?)

8. What steps are necessary to prevent reoccurrence of a similar injury?	8a. Have you taken these steps? <input type="checkbox"/> YES <input type="checkbox"/> NO If "NO," explain.
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9. Witnesses' names: