Reset Form

City of Torrance, Finance/Risk Management

EMPLOYEE'S REPORT OF INDUSTRIAL INJURY OR ILLNESS

3031 Torrance Blvd., Torrance, CA 90503 (310) 618-2950 ***RECORD ONLY*** ☐ ***Yes*** ☐ ***No***

Instructions: To be completed by the injured employee and submitted as soon as possible following accident or onset of illness.

BACKGROUND			
NAME OF EMPLOYEE		EMPLOYEE NO.	SOCIAL SECURITY NUMBER
HOME ADDRESS CITY ZIP CODE			HOME PHONE
DEPARTMENT	DIVISION	WORK LOCATION	WORK PHONE
JOB TITLE			WAGES
DATE OF BIRTH	DATE OF HIRE	SHIFT HOURS	DAYS PER WEEK

INJURY/ILLNESS INFORMATION	
DATE OF INJURY/ONSET OF ILLNESS	TIME OF INJURY/ILLNESS ☐ A.M. ☐ P.M.
LOCATION OF INJURY/ILLNESS STREET(S) ZIP CODE CITY	
Describe your activity at the time you were injured. (Please be specific.)	
Describe your injury including parts of body affected.	
Were there witnesses? Yes ☐ No ☐	
If yes, provide the names, work locations, addresses, and phone numbers of witnesses.	
Have you requested medical care for your injury/illness? Yes ☐ No ☐	
If yes, provide names, addresses, and phone numbers of the doctors who have treated you for this injury/illness.	
Name of Torrance employee authorizing medical care.	
Did you/will you miss work after your injury? Yes ☐ No ☐	
If yes, please give dates.	

ORIGINAL-Finance/Risk Management **YELLOW**-Department **PINK**-Employee

EMPLOYEE'S REPORT OF INDUSTRIAL INJURY OR ILLNESS (cont.)

Name of Employee _____ Date _____

Did/will you return to work?	Yes ☐	No ☐
If yes, please give date of return.		
Did you report this injury or illness to your supervisor?	Yes ☐	No ☐
If yes, when and to whom?		
Do you have outside employment in addition to your job at the City?	Yes ☐	No ☐
If yes, please describe your outside employment.		
Did your outside employment cause or aggravate your injury/illness?	Yes ☐	No ☐
Do you engage in any sports or activities that involve physical activity while off duty? (such as softball, bowling, golf, skiing, etc.)	Yes ☐	No ☐
If yes, please describe.		
Did the outside activity cause or aggravate your injury?	Yes ☐	No ☐
If yes, please describe.		
Do you feel an unsafe condition caused or contributed to the accident/injury?	Yes ☐	No ☐
If yes, please describe.		

Signature of Employee	Date Signed
Signature of Supervisor	Date Signed
Signature of Department Head	Date Signed

ORIGINAL-Finance/Risk Management **YELLOW**-Department **PINK**-Employee