

# UCD Student's Report of Injury or Illness – Animal Science

University Policy requires that industrial injury/illness be reported within one working day of occurrence. This form must be filled out in its entirety and sent to the Department Safety Coordinator, within one working day of notice of injury. Students who are also employees may need to fill out the Workers' Compensation form instead of this one.

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## Student Data:

Name \_\_\_\_\_ Home Phone (\_\_\_\_) \_\_\_\_\_  
Address \_\_\_\_\_ City/State/Zip \_\_\_\_\_  
Student I.D. Number \_\_\_\_\_ Sex: M\_\_\_\_ F\_\_\_\_ Birthdate \_\_\_\_\_  
Supervisor's Name \_\_\_\_\_ Supervisor's Phone (\_\_\_\_) \_\_\_\_\_  
Student usually spends \_\_\_\_\_ hrs/wk in the lab/facility/class Work Phone (\_\_\_\_) \_\_\_\_\_  
Designation of class \_\_\_\_\_ Room number of lab/ name of facility \_\_\_\_\_

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## Injury Data:

Date of Injury/Illness \_\_\_\_\_ Time of Injury \_\_\_\_\_ Time began work/class \_\_\_\_\_  
Supervisor notified of Injury/Illness on \_\_\_\_\_ Form provided on \_\_\_\_\_  
Unable to work for at least one full day after injury date? Yes\_\_\_\_ No\_\_\_\_  
Date last worked \_\_\_\_\_ Date returned to work/class \_\_\_\_\_

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## Student Statement:

Describe the Injury/Illness \_\_\_\_\_  
\_\_\_\_\_  
Describe how it occurred \_\_\_\_\_  
\_\_\_\_\_  
Specific activity you were performing \_\_\_\_\_  
\_\_\_\_\_  
Describe where it occurred \_\_\_\_\_  
\_\_\_\_\_  
Have you been treated by a Physician for this Injury/Illness? Yes\_\_\_\_ No\_\_\_\_  
If Yes, names, addresses, & phone numbers of attending physicians \_\_\_\_\_  
\_\_\_\_\_  
Student's Signature \_\_\_\_\_ Date \_\_\_\_\_

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## Supervisor's Statement:

Describe the circumstances of the injury in detail \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
If you feel student's condition is not related to his work in your lab/facility/class, please explain & provide any evidence you have to support this \_\_\_\_\_  
\_\_\_\_\_  
What steps have you taken, or will you take, to prevent similar injury/illness? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Supervisor's signature \_\_\_\_\_ Date \_\_\_\_\_