COLLEGE OF MARIN

RETURN COMPLETED FORM TO:
Ron Owen, Benefits Office
Indian Valley Campus

Marin Community College District
Human Resources Department

SUPERVISOR'S REPORT OF EMPLOYEE INCIDENT OR INJURY

SUPPLEMENTAL QUESTIONNAIRE

(Please type or print clearly)

NAME OF INJURED WORKER: _____

ADDITIONAL EMPLOYMENT INFORMATION

1. Is Injured Worker a 10- or 12-Month Employee? ☐ 10 Mo. ☐ 12 Mo.
2. Regular Work Days: _____
3. Regular Work Hours: _____
4. Total Weekly Hours: _____
5. What Is Employee's Salary? _____
6. Is Employee's Salary Being Continued? ☐ Yes ☐ No
7. Job Title: _____
8. Last Date Worked: _____
9. Was the Employee Paid a Full Day's Wages on the Date of Injury? ☐ Yes ☐ No
10. Was the Claim Form Provided? ☐ Yes ☐ No
    On What Date? _____
    By Whom? _____
11. To Whom Was the Injury Reported? _____
12. Were There Any Safety Hazards Involved? ☐ Yes ☐ No If Yes, Explain: _____
    If Yes, Have They Been Corrected? ☐ Yes ☐ No
13. Is There an Opportunity for Subrogation or Third-Party Recovery? ☐Yes ☐No
14. Does the Employer Find This to Be A Questionable Claim? ☐ Yes ☐ No
    If So, Why? _____
    Is Employee Still Off Work? ☐ Yes ☐ No
16. Is the Employer Able to Accommodate Modified Duty? ☐ Yes ☐ No
17. What Date Did Employee Return to Work? _____
18. Did the Employee Return to Full or Modified Duty? ☐ Full ☐ Modified