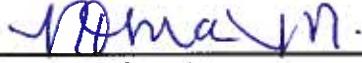


SUPERVISOR'S SUMMARY OF MISHAP

THIS FORM SHOULD BE COMPLETED BY SUPERVISOR

| | | | |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| 1. Employee's Name (Last first, middle) Norma Martinez | | 2. Home Mailing Address (Number, street, city, state, Zip code) 5550 Balboa Arms Drive #88, San Diego, Ca 92117 | |
| 3. Date of Birth (MMDDYYYY) 10/28/1972 | 4. Sex: <input checked="" type="checkbox"/> MALE <input type="checkbox"/> FEMALE | 5. Employee ID Number: Temp employee | 6. Home Telephone Area Code Number (619-642-6628) |
| 7. Name and Address of Employer MARINE CORPS COMMUNITY SERVICES 3800 CHOSIN AVENUE Bldg. 5 SAN DIEGO, CA 92140-5196 | | 8. Employee's Job Title Prep cook Department: 2602 Department Extension: 02 | Circle days usually worked each week Full time / Part time / Flex This is a Temp employee for Event Services Hours scheduled each day of week of injury: S M T W T F S <input checked="" type="checkbox"/> <input checked="" type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> |
| 9. Date of Injury: (MMDDYYYY) 6/15/2025 | 10. Hour of injury 14 : 45 <input checked="" type="checkbox"/> AM <input type="checkbox"/> PM | 11. Place Where Injury Occurred (Dept, Bldg #, Landmarks) Building 132 Back Kitchen area | 12. Name of Supervisory at Time of Injury Robert Hanley Emp #: 129228 |
| 13. Work Due to Injury/ leave work Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | | 14. If Yes, Date Stopped / / | 15. Cause of Injury (Explain in what way the injury or occupational illness was caused by employment) (wet floor, improper training, inattention, etc.) Employee slipped on some grease spilled on the floor |
| 16. Effects of Injury (indicate parts of body affected or if death occurred) (left/right hand, etc.) Fell on her right knee causing swelling and bruising | | | |
| 17. If injury is a result of lifting, approximate weight of item. _____ | | | |
| 18. Has medical attention been requested? no | | | |
| 19. What action would you recommend to prevent reoccurrence of the mishap? Clean up spills immediately | | | |
| 20.  Signature of Employee | | 6/15/25 Date  Signature of Supervisor Robert Hanley Printed Name of Supervisor 6/15/25 Date Supervisor/Manager knew of the accident | |
| Date Received at Human Resources _____ | | 6/15/25 Date Supervisor/Manager knew of the accident | |