

This report to be completed when occupational illness or incident occurs. If an employee is injured or develops a job-related illness (developed gradually e.g., tendonitis) as a result of their employment at UC they must complete and submit the "Incident Report". If the employee is unable to complete the form, the supervisor must complete on their behalf.

Please complete each section. When you have completed the form and are satisfied with your answers please give this form to your supervisor.

Incident Reporting ensures there is a record on file with the employer. In no way does this waive the employee's right to workers' compensation benefits. If an injury occurs, first aid may be appropriate treatment. "First aid" means any one-time treatment and any follow-up visit(s) for the purpose of observation of minor scratches, cuts, burns, splinters, or other minor industrial incident, which do not ordinarily require medical care. This one-time treatment and follow-up visit for the purpose of observation is considered first aid even though provided by a physician or registered professional personnel. Filing of a first aid incident report is not a filing of a workers' compensation claim. An employee retains their right to file a workers' compensation claim at a later date.

University of California
INCIDENT REPORT

Section #1

EMPLOYEE INFORMATION:

Employee Completes This Section

Campus: _____ Last four digits of social security number: _____
Name **PRINT**: _____ Sex Male Female
Home Address: _____ City: _____ Zip: _____
Home Phone: _____ Work Phone: _____
Department: _____ Job Title: _____
Work Hours: _____ Hours Worked per Week: _____
Employment Type full-time part-time regular temporary seasonal student volunteer appointment
Do you have other employment? yes no If so, where _____

INCIDENT INFORMATION

Date of Incident _____ Time of Incident: _____
Address/Bldg, name & room # of incident: _____
Zip Code _____
State all parts of body and type of injuries involve (e.g. bruised right elbow)

Describe how incident occurred:

Was incident reported? yes no If "yes" to whom? _____

Date reported: _____

Were there witnesses? yes no unknown

Name of Witness #1 (First and Last): _____

Witness #1 Phone Number: _____

Name of Witness #2 (First and Last): _____

Witness #2 Phone Number: _____

Is this a new injury? yes no If "yes" indicate date, If "no", please indicate date of original injury

INITIAL MEDICAL TREATMENT

Was treatment received for this injury?

No medical treatment- reporting only Declined treatment at this time Treatment was/will be provided

Treatment was provided by: Self Occupational Health Emergency Room Other (please specify below)

If treatment was provided, name and location of medical provider.

Name: _____ Address: _____

Phone: _____

I, the injured employee, herein certify the information above is true and to best of my knowledge

Date: _____ Signature of Employee: _____

Section #2

SUPERVISOR COMPLETES THIS SECTION:

Supervisor Name: _____ email address _____

Work Phone: _____

Describe how the employee was injured. _____

Did employee lose time from work? _____ _yes_ _no_ _unknown If 'yes' First day of lost time

Was the Employee paid for the full date of injury? _ yes _ no

Date Employee returned to Work. _____

Was there equipment involved? _yes_ _no_ If answered "yes" what was the equipment

What action will be taken to prevent recurrence? _____

Other Comments:

Date: _____ Signature: _____ Title: _____

Section #3

MEDICAL PROVIDER COMPLETES THIS SECTION:

Medical Provider - What treatment was provided for this injury (check one) _ First Aid _ Medical Treatment

Return To Work: Can Return immediately _yes_ _no

If no, date employee can return to work _____ _Full duty_ _Restricted work

Employee can return to work with these specific restrictions: _____

Estimated period of absence: _____ to _____ Next appointment: _____

Date: _____ Signature: _____ Title: _____

Note: If, initially, first aid is rendered but at a later date treatment beyond first aid is required, please contact the Workers' Compensation Department immediately and initiate the filing of a workers' compensation claim. Seeking first aid treatment and completion of this report does not waive the employee's right to file a workers' compensation claim and seek benefits in accordance with statutory workers' compensation laws. A physician who treats an injured employee is required to file a 5021 ("Doctor's First Report of Injury") with the claims administrator for every work illness or injury, even first aid cases where there is no lost time from work.