

UCD Employer's Report of Occupational Injury or Illness

UNIVERSITY POLICY REQUIRES THAT INDUSTRIAL INJURY/ILLNESS BE REPORTED TO WORKERS' COMPENSATION WITHIN 24 HOURS OF OCCURRENCE AND STATE REGULATIONS REQUIRE THAT ALL ACCIDENTS BE INVESTIGATED.

In the event of a serious injury or hospitalization, call Workers' Compensation immediately at (530) 752-7243. This form must be completed in its entirety and mailed or faxed (530) 752-3439 to Workers' Compensation. Omission of information could result in a delay of benefits.

EMPLOYEE MUST COMPLETE THESE SECTIONS:

EMPLOYEE DATA	Employee Name:		Employee's UC Davis ID #:	
	Address:		Home Phone: ()	
	City/State/Zip:		Sex: <input type="checkbox"/> Female <input type="checkbox"/> Male	Date of Birth:
	Department/Location:		Employee's Work Phone: ()	
	Payroll Title/TC:	Date of Hire:	Annual Gross Salary: \$	
	Supervisor's Name:		Supervisor's Work Phone: ()	
	Employee () Volunteer () Student-Employee ()		() hours per day	() days per week () total weekly hours

EMPLOYEE STATEMENT	Specific Injury/Illness/Exposure:		Body Part(s) affected:	Date of injury/illness:
	Location where injury or illness occurred:			Others Injured? <input type="checkbox"/> Yes <input type="checkbox"/> No
	What equipment, materials or chemicals caused the injury/illness? :			Who witnessed this injury?
	Explain in detail how the injury occurred. Include specific activities/tasks performed at the time.			
	Medical Treatment provided by: ____ Employee Health Services ____ Sutter Davis Hospital ER Other: (Provide Name & Phone #) _____ ____ Private Physician ____ UC Davis Medical Center ____ First Aid, no medical care needed.			
	Employee Signature:			Today's Date:

EMPLOYER'S INVESTIGATION AND STATEMENT (EMPLOYER COMPLETES):

EMPLOYER	After the investigation, explain in detail how the injury/illness occurred and the specific activity being performed:	
What was the injury, illness or exposure?		

INITIAL CAUSE	CONTRIBUTING FACTORS AND ACTIVITIES	PREVENTIVE ACTIONS
<input type="checkbox"/> Struck by or against object (indicate) <input type="checkbox"/> Caught in/under/ between <input type="checkbox"/> Fall / Slip / Trip <input type="checkbox"/> Material handling or lifting <input type="checkbox"/> Repetitive motion <input type="checkbox"/> Chemical exposure <input type="checkbox"/> Body fluid exposure: ___ Needle stick ___ Sharps <input type="checkbox"/> Animal bite <input type="checkbox"/> Other, Explain _____ _____ _____	Equipment <input type="checkbox"/> Equipment failure <input type="checkbox"/> Equipment unavailable <input type="checkbox"/> Improper equipment or material used for job Personal protective equipment <input type="checkbox"/> Not worn <input type="checkbox"/> Not readily available <input type="checkbox"/> Not adequate for the task <input type="checkbox"/> Personal protective equipment failure Training/Experience <input type="checkbox"/> Lack of training <input type="checkbox"/> Safety training provided, not followed <input type="checkbox"/> New task for employee or lack of experience Work Area <input type="checkbox"/> Work area set up improperly <input type="checkbox"/> Inadequate lighting or noise issues <input type="checkbox"/> Housekeeping issues <input type="checkbox"/> Environmental factors (rain, wind, temp. etc) Employee <input type="checkbox"/> Physically not able to do work <input type="checkbox"/> Employee fatigue <input type="checkbox"/> Unbalanced or poor position or motion <input type="checkbox"/> Incorrect procedures used for task <input type="checkbox"/> Other unsafe practice Assistance <input type="checkbox"/> Difficult to perform task without help <input type="checkbox"/> Safety features or devices not readily available <input type="checkbox"/> Assistive devices not used <input type="checkbox"/> Lack of policy/procedure <input type="checkbox"/> Animal (explain below) _____ <input type="checkbox"/> Other (explain) _____ Use additional pages as needed	SUPERVISOR WILL: <input type="checkbox"/> Develop/revise safety procedures and update IIPP or Chem. Hyg. Plan <input type="checkbox"/> Request ergonomic evaluation <input type="checkbox"/> Order new equipment <input type="checkbox"/> Order new personal protective equipment <input type="checkbox"/> Remove equipment from use and repair/replace <input type="checkbox"/> Schedule preventive maintenance <input type="checkbox"/> Will retrain employee before task is re-assigned. <input type="checkbox"/> Perform on-site review of work activity, update job safety analysis. <input type="checkbox"/> Reconfigure work area <input type="checkbox"/> Communicate corrective actions to others in job category. <input type="checkbox"/> Other _____ Preventive actions will be completed by: Name _____ Expected date of completion _____

SUPERVISOR'S OR MANAGER'S SIGNATURE:		Date of Investigation:
DEPARTMENT HEAD'S SIGNATURE:		Date: