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) 757-3266. This form must be completed in its entirety and mailed or faxed (530-757-7779) to Workers' Compensation. Omission of information could result in a delay of benefits.

EMPLOYEE MUST COMPLETE THESE SECTIONS:

EMPLOYEE DATA

Employee Name:		Employee's UCDavis ID #:
Address:		Home Phone: ( )
City/State/Zip:	Sex: ☐Female ☐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? ☐Yes ☐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

- ☐ Struck by or against object (indicate) _____
- ☐ Caught in/under/ between
- ☐ Fall / Slip / Trip
- ☐ Material handling or lifting
- ☐ Repetitive motion
- ☐ Chemical exposure
- ☐ Body fluid exposure:
  - __Needle stick
  - __Sharps
- ☐ Animal bite
- ☐ Other, Explain

_____
_____
_____
_____
_____

CONTRIBUTING FACTORS AND ACTIVITIES

Equipment
- ☐ Equipment failure
- ☐ Equipment unavailable
- ☐ Improper equipment or material used for job

Personal protective equipment
- ☐ Not worn
- ☐ Not readily available
- ☐ Not adequate for the task
- ☐ Personal protective equipment failure

Training/Experience
- ☐ Lack of training
- ☐ Safety training provided, not followed
- ☐ New task for employee or lack of experience

Work Area
- ☐ Work area set up improperly
- ☐ Inadequate lighting or noise issues
- ☐ Housekeeping issues
- ☐ Environmental factors (rain, wind, temp. etc)
- ☐ Ventilation issues
- ☐ Ergonomic factors

Employee
- ☐ Physically not able to do work
- ☐ Employee fatigue
- ☐ Unbalanced or poor position or motion
- ☐ Incorrect procedures used for task
- ☐ Other unsafe practice

Assistance
- ☐ Difficult to perform task without help
- ☐ Safety features or devices not readily available
- ☐ Assistive devices not used

☐ **Lack of policy/procedure**
☐ **Animal** (explain below)
☐ **Other** (explain) _____

_____
_____
_____

Use additional pages as needed

PREVENTIVE ACTIONS

SUPERVISOR WILL:
- ☐ Develop/revise safety procedures and update IIPP or Chem. Hyg. Plan
- ☐ Request ergonomic evaluation
- ☐ Order new equipment
- ☐ Order new personal protective equipment
- ☐ Remove equipment from use and repair/replace
- ☐ Schedule preventive maintenance
- ☐ Will retrain employee before task is re-assigned.
- ☐ Perform on-site review of work activity, update job safety analysis.
- ☐ Reconfigure work area
- ☐ Communicate corrective actions to others in job category.
- ☐ 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:**

PLEASE NOTE: COMPLETING THIS FORM IS NOT AN ADMISSION OF UNIVERSITY LIABILITY

1/2006 ER: WC/H/MJB