UCM EMPLOYEE & SUPERVISOR INCIDENT REPORT

Incident Reporting ensures there is a record of the incident on file and helps UC Merced provide a safe work environment. The supervisor is responsible for assuring that all employee incidents, injuries, illnesses, or repetitive conditions are reported to HR/Workers' Compensation within 24 hours of the initial report from the employee. If the employee is unable to complete the Employee section of the form, the supervisor must complete on his/her behalf.

In filing this Incident Report an employee is not filing a workers' compensation claim. To file a claim, the employee fills out a **Workers' Compensation Claim Form (DWC 1)**. It is not necessary to fill out a Workers' Compensation Claim Form (DWC 1) to obtain first-aid treatment for a minor work-related injury. "First-Aid' means any one-time treatment, and any follow-up visit for the purpose of observation of minor scratches, cuts, burns, splinters, or other minor industrial injury, which do not ordinarily require medical care. This one-time treatment, and any follow-up visit for the purpose of observation, is considered first-aid even though provided by a physician or registered professional personnel.

UNIVERSITY OF CALIFORNIA — UCMERCED — Human Resources

Please contact **HR/Workers' Compensation** if you have any questions about this form or incident reporting requirements:

Email: benefits@ucmerced.edu
Phone: (209) 228-2363
Website: http://hr.ucmerced.edu

Instructions

Supervisor: Please give this form to the injured employee and ask him/her to fill out the Employee section of the form. Once the employee has completed the Employee section of this form, complete the Supervisor section to the best of your ability. If the employee needs or requests examination or treatment by a medical provider, please give the employee the **UC Merced Authorization for Medical Treatment Form** and immediately arrange for medical care following the instructions on that form. In the event of a serious injury, fatality, or hospitalization, contact HR/Workers' Compensation immediately at (209) 228-2363.

Once the form has been completed, please distribute as follows:

Distribution: (within 24 hours)	**Fax:**	**HR/Workers' Compensation (209) 228-8586**	**Original:**	**HR/Workers' Compensation Human Resources Dept**	**Copies::**	**Employee** **Supervisor** **MSO for Department** **Environmental Health & Safety**

EMPLOYEE COMPLETES THIS SECTION:

Employee Name:	UC Merced ID #:	Date of Birth:
Address:	Home Phone:	Work Phone:
City/State/Zip:	Sex: ☐Female ☐Male	
Department:	Supervisor's Name:	

Occupation:	Date of Hire:	Annual Gross Salary: $	Paid: ☐ Monthly ☐ Biweekly

Appointment Type: ☐ Regular ☐ Limited ☐ Contract ☐ Student ☐ Volunteer	Full time/Part time: ☐ Full time ☐ Part time	Title:

Days and hours normally worked:
☐ Monday ___ hours ☐ Tuesday ___ hours ☐ Wednesday ___ hours ☐ Thursday ___ hours ☐ Friday ___ hours ☐ Saturday ___ hours ☐ Sunday ___ hours

Do you have other employment? ☐ Yes ☐ No	If yes, where else are you employed?

Specific Injury/Illness/Exposure:	Body Part(s) affected:	Date of injury/illness:	Time of injury/illness:

Location where injury or illness occurred (please include building & room number):	Were others injured? ☐Yes ☐No
What equipment, materials or chemicals caused the injury/illness?	Who witnessed this injury?

Describe in detail how the injury/illness occurred and the specific activity being performed:

Is this a brand new injury? ☐ Yes ☐ No	If no, what is the date of the original injury?	Was the original injury reported? ☐ Yes ☐ No	If yes, who was it reported to?

Do you want to see a doctor for treatment?
☐ Yes ☐ No

I, the injured employee, hereby certify that the information above is true and to the best of my knowledge: **EMPLOYEE'S SIGNATURE:**	**Date:**

SUPERVISOR COMPLETES THIS SECTION:

Supervisor Name:	Phone:	Email:

What was the injury, illness or exposure?

Describe in detail how the injury/illness occurred and the specific activity being performed:

Date of the incident:	Date employee reported incident:	Time employee began work: _____ ☐ AM ☐ PM	Time employee stopped work: _____ ☐ AM ☐ PM

Is the employee likely to lose additional time from work? ☐ Yes ☐ No ☐ Unknown	Is the department willing to provide transitional (modified or alternative) work during the employee's recovery: ☐ Yes ☐ No

Was equipment involved? ☐ Yes ☐ No	If yes, what type of equipment?	Did equipment malfunction cause the incident? ☐ Yes ☐ No ☐ Unknown	**If yes, remove equipment, tag for identification, then contact EH&S at (209) 228-7864.**

Will the employee seek medical treatment? ☐ Yes ☐ No	**If yes, please complete the UC Merced Authorization for Medical Treatment Form and give it to the employee to take to the clinic.**

Other comments:

INITIAL CAUSE	CONTRIBUTING CONDITIONS AND BEHAVIORS		PREVENTIVE ACTIONS
☐ Struck by or against object ☐ Caught in/under/between ☐ Contact by/with ☐ Slip/Trip/Fall ☐ Material handling/lifting ☐ Repetitive motion ☐ Over-exertion ☐ Chemical exposure ☐ Explosion ☐ Body fluid exposure: ☐ Needle stick ☐ Sharps ☐ Animal bite ☐ Vehicular accident ☐ Other	**Equipment** ☐ Equipment failure ☐ Equipment unavailable ☐ Improper equipment used **Personal protective equipment** ☐ Not worn ☐ Not readily available ☐ Not adequate for the task ☐ Protective equipment failure **Training/Experience** ☐ Lack of training ☐ Safety protocol not followed ☐ New task or lack of experience **Work Area** ☐ Work area set up improperly ☐ Inadequate lighting ☐ 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/motion ☐ Incorrect procedures used for task ☐ Other unsafe practice **Assistance** ☐ Difficult to perform task without help ☐ Safety features/devices not available ☐ Assistive devices not used ☐ **Lack of policy/procedure** ☐ **Animal** (explain below) ☐ **Other**	**SUPERVISOR WILL:** ☐ Develop or revise safety procedures ☐ Request ergonomic evaluation from EH&S ☐ Request safety training from EH&S ☐ Order new equipment ☐ Provide protective equipment ☐ Remove equipment from use and repair or replace ☐ Schedule preventive maintenance ☐ Retrain employee ☐ Post safety signs ☐ Reconfigure work area ☐ Communicate corrective actions to others ☐ Other **Preventive actions will be completed by:** Name: Expected date of completion:

List any other actions that will be taken to prevent recurrence:

SUPERVISOR'S OR MANAGER'S SIGNATURE:	**Date:**

For HR/WC Use Only

Claim Status: ☐ First Aid Only ☐ WC Claim **Date Entered in VOS:** _____
Letter: ☐ Regular ☐ No ESL **Entered by:** _____
DWC-1 Needed: ☐ Yes ☐ No

PLEASE NOTE: COMPLETING THIS FORM IS NOT AN ADMISSION OF UNIVERSITY LIABILITY **03/2007**