UCM EMPLOYEE & SUPERVISOR INCIDENT REPORT

Supervisor and employee must complete this report when an occupational injury, illness or incident occurs, or a job-related illness develops gradually (e.g. tendonitis) as a result of UCM employment. If the employee is unable to complete or sign the form, the supervisor or department representative must complete on their behalf.

Email the completed form within 24 hours of knowledge to Workers' Compensation benefits@ucmerced.edu with a copy to Environmental Health and Safety bcollier2@ucmerced.edu

UCMERCED

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

Email: benefits@ucmerced.edu
Phone: (209) 259-8806
Website: https://hr.ucmerced.edu/benefits/workers-compensation-0

Note: If an accident results in an employee to be hospitalized, other than for observation, for 24 hours or more, or a loss of a limb (amputation) or loss of life, notify Workers' Compensation Office and Environmental Health and Safety (EH&S) immediately. EH&S must report such accidents to OSHA within 8 hours of the event.

EMPLOYEE INFORMATION

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

EMPLOYMENT INFORMATION

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	Job 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?

INCIDENT INFORMATION

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

Location where injury or illness occurred (street, building, room):	Were others injured? ☐Yes ☐No

Were there witnesses to this incident? ☐ Unknown ☐ No ☐ Yes - If yes, witness name(s) and phone number (s):

What happened? Describe in detail how the incident occurred (the specific activity being performed; equipment, material, tools or chemicals being used):

Is this a 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 hereby certify that the information above is true and to the best of my knowledge. **EMPLOYEE SIGNATURE:**	**Date:**

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

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 and able 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**

Will the employee seek medical treatment? ☐ Yes ☐ No	**If yes, phone Workers' Compensation for authorization 209-228-4705.**

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 or control measures that will be put in place to prevent recurrence:

SUPERVISOR OR DEPARTMENT REPRESENTATIVE SIGNATURE:	**Date:**

For WC Use Only

Claim Status: ☐ First Aid Only ☐ WC Claim
Letter: ☐ Regular ☐ No ESL
DWC-1 Needed: ☐ Yes ☐ No

Date Entered in iVOS: _____
Entered by: _____