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 diniguez3@ucmerced.edu.

If injury was to a student that is not employed by UCM, do NOT complete this form. Student should complete the UCM Incident report located http://risk.ucmerced.edu/report-claim/report-incident and seek medical treatment at the student health center.

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

Email: benefits@ucmerced.edu
Phone: (209) 228-8247 Option 4
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.

Required fields are marked with an *

EMPLOYEE INFORMATION

Employee Name: *		UC Merced ID #: *	Date of Birth:
Address:		Home Phone:	Work Phone:
City:	State:	Zip:	Sex: ☐ Female ☐ Male

EMPLOYMENT INFORMATION

Department: *		Supervisor Name: *	
Occupation:	Job Title:		Date of Hire:
☐ Full time ☐ Part time	Annual Gross Salary: $		Paid: ☐ Monthly ☐ Biweekly
Appointment Type: ☐ Regular ☐ Limited ☐ Contract ☐ Volunteer ☐ Student		If student, did the incident occur as direct result of course of ☐ Study or ☐ Employment?	
Days and hours normally worked: ☐ Mon___hrs ☐ Tues___hrs ☐ Wed ___hrs ☐ Thurs___hrs ☐ Fri ___hrs ☐ Sat___hrs ☐ Sun___hrs			
Do you have other employment? ☐ Yes ☐ No	If yes, where else are you employed?		

INCIDENT INFORMATION

Incident Type:* ☐ Injury ☐ Illness ☐ Exposure ☐ Near miss ☐ Release to the environment ☐ Vehicle Collision Incident ☐ Safety Concern

Specific Injury/Illness/Exposure: *			Body Part(s) affected: *
Date of injury/illness: *	Time of injury/illness: *	Were others injured? ☐Yes ☐No	Were there witnesses to this incident? ☐ No ☐ Yes ☐ Unknown
Incident Location (building, room): *	Address where injury or illness occurred (street, city, state): *		If yes, witness name(s) and phone number(s):

What happened? Describe in detail how the incident occurred (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? _____	
Initial Treatment: * ☐ Want to see a doctor for treatment ☐ No Medical Treatment (First Aid Only)		DWC-1 provided? ☐ 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:

Type of incident?* ☐ Injury ☐ Illness ☐ Exposure ☐ Near miss ☐ Release to the environment ☐ Vehicle Collision ☐ Safety Concern

OSHA Injury or Illness: ☐ All other illnesses ☐ Hearing loss ☐ Injury ☐ Poisoning ☐ Respiratory condition ☐ Skin disorder

For exposure incidents in labs, contact EH&S at (209) 228-2347 or biosafety@ucmerced.edu

What was the specific injury/illness or exposure? *

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

Location where injury/illness occurred (building, room number): *

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 (Receive First Aid Only)	DWC-1 provided? ☐ Yes ☐ No	**If yes, phone Workers' Compensation for authorization (209) 228-8247 Option 4 or (209) 259-8806**

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:**