

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



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: <input type="checkbox"/> Female <input type="checkbox"/> Male	
Department:	Supervisor's Name:	

EMPLOYMENT INFORMATION

Occupation:	Date of Hire:	Annual Gross Salary: \$	Paid: <input type="checkbox"/> Monthly <input type="checkbox"/> Biweekly
Appointment Type: <input type="checkbox"/> Regular <input type="checkbox"/> Limited <input type="checkbox"/> Contract <input type="checkbox"/> Student <input type="checkbox"/> Volunteer	Full time/Part time: <input type="checkbox"/> Full time <input type="checkbox"/> Part time	Job Title:	
Days and hours normally worked: <input type="checkbox"/> Monday ___ hours <input type="checkbox"/> Tuesday ___ hours <input type="checkbox"/> Wednesday ___ hours <input type="checkbox"/> Thursday ___ hours <input type="checkbox"/> Friday ___ hours <input type="checkbox"/> Saturday ___ hours <input type="checkbox"/> Sunday ___ hours			
Do you have other employment? <input type="checkbox"/> Yes <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No
Were there witnesses to this incident? <input type="checkbox"/> Unknown <input type="checkbox"/> No <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No	If no, what is the date of the original injury?	Was the original injury reported? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, who was it reported to?
Do you want to see a doctor for treatment? <input type="checkbox"/> Yes <input type="checkbox"/> No			

I hereby certify that the information above is true and to the best of my knowledge.

EMPLOYEE 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: <input type="checkbox"/> AM <input type="checkbox"/> PM	Time employee stopped work: <input type="checkbox"/> AM <input type="checkbox"/> PM	
Is the employee likely to lose additional time from work? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		Is the department willing and able to provide transitional (modified or alternative) work during the employee's recovery? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Was equipment involved? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, what type of equipment?	Did equipment malfunction cause the incident? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	If yes, remove equipment, tag for identification, then contact EH&S	
Will the employee seek medical treatment? <input type="checkbox"/> Yes <input type="checkbox"/> No		If yes, phone Workers' Compensation for authorization 209-228-4705.		
Other comments:				
INITIAL CAUSE	CONTRIBUTING CONDITIONS AND BEHAVIORS		PREVENTIVE ACTIONS	
<input type="checkbox"/> Struck by or against object <input type="checkbox"/> Caught in/under/between <input type="checkbox"/> Contact by/with <input type="checkbox"/> Slip/Trip/Fall <input type="checkbox"/> Material handling/lifting <input type="checkbox"/> Repetitive motion <input type="checkbox"/> Over-exertion <input type="checkbox"/> Chemical exposure <input type="checkbox"/> Explosion <input type="checkbox"/> Body fluid exposure: <input type="checkbox"/> Needle stick <input type="checkbox"/> Sharps <input type="checkbox"/> Animal bite <input type="checkbox"/> Vehicular accident <input type="checkbox"/> Other	Equipment <input type="checkbox"/> Equipment failure <input type="checkbox"/> Equipment unavailable <input type="checkbox"/> Improper equipment used 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"/> Protective equipment failure Training/Experience <input type="checkbox"/> Lack of training <input type="checkbox"/> Safety protocol not followed <input type="checkbox"/> New task or lack of experience Work Area <input type="checkbox"/> Work area set up improperly <input type="checkbox"/> Inadequate lighting <input type="checkbox"/> Noise issues <input type="checkbox"/> Housekeeping issues <input type="checkbox"/> Environmental factors (rain, wind, temp. etc) <input type="checkbox"/> Ventilation issues <input type="checkbox"/> Ergonomic factors		Employee <input type="checkbox"/> Physically not able to do work <input type="checkbox"/> Employee fatigue <input type="checkbox"/> Unbalanced or poor position/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/devices not 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	SUPERVISOR WILL: <input type="checkbox"/> Develop or revise safety procedures <input type="checkbox"/> Request ergonomic evaluation from EH&S <input type="checkbox"/> Request safety training from EH&S <input type="checkbox"/> Order new equipment <input type="checkbox"/> Provide protective equipment <input type="checkbox"/> Remove equipment from use and repair or replace <input type="checkbox"/> Schedule preventive maintenance <input type="checkbox"/> Retrain employee <input type="checkbox"/> Post safety signs <input type="checkbox"/> Reconfigure work area <input type="checkbox"/> Communicate corrective actions to others <input type="checkbox"/> 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: <input type="checkbox"/> First Aid Only <input type="checkbox"/> WC Claim	Date Entered in iVOS: _____
Letter: <input type="checkbox"/> Regular <input type="checkbox"/> No ESL	Entered by: _____
DWC-1 Needed: <input type="checkbox"/> Yes <input type="checkbox"/> No	