UCSF CAMPUS

# EMPLOYEE INCIDENT REPORT
## (FOR REPORTING WORK-RELATED INJURIES & ILLNESSES)

Employees must complete this Incident Report when they sustain a work-related injury or illness.

Complete this Incident Report and return it to Campus HR DMS at the fax number and/or address at the bottom of this form.

Incident Reporting ensures there is a record of the incident on file, and helps UCSF provide a safe work environment.

In filing this Incident Report you are not filing a workers' compensation claim. You file a claim by filling 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.

If your physician indicates that your injury requires medical treatment beyond first-aid or certifies disability beyond your work-shift at the time of injury, Campus HR DMS will provide you with a Workers' Compensation Claim Form (DWC 1) & Notice of Potential Eligibility.

**EMPLOYEE**

| EMPLOYEE NAME (PLEASE PRINT) | Employee ID: 02 | WORK PHONE | HOME PHONE |
|---|---|---|---|
| HOME STREET ADDRESS | | | |
| CITY, STATE, ZIP CODE | OCCUPATION/JOB TITLE | | |
| DEPARTMENT NAME | SUPERVISOR NAME (PLEASE PRINT) | | SUPERVISOR PHONE |
| DO YOU HAVE OTHER EMPLOYMENT? ☐ YES ☐ NO | IF YES, WHERE? | | |

**INCIDENT**

| DATE OF INCIDENT | TIME OF INCIDENT PM | TIME BEGAN WORK: PM | TIME STOP WORK PM | FINISHED SHIFT? ☐ YES ☐ NO |
|---|---|---|---|---|
| LOCATION OF INCIDENT (ADDRESS, BUILDING NAME, ROOM NUMBER, CITY, STATE, ZIP): | | | | ON UC PROPERTY? ☐ YES ☐ NO |
| HOW DID THE INCIDENT OCCUR? DESCRIBE THE ACTIVITY AND ANY TOOLS, EQUIPMENT, OR MATERIAL YOUR WERE USING *(Example: I was opening a box of paper using an exacto-knife. The exacto-knife slipped on the surface of the box, and cut the skin of my right index finger.)*: | | | | |
| LIST THE BODY PART(S) INJURED AND TYPE OF INJURY (Example: Skin cut on right index finger.): | | | | |
| HOW DO YOU THINK THIS TYPE OF INCIDENT CAN BE PREVENTED? (Example: By wearing protective gloves while using exacto-knife.): | | | | |

| INCIDENT REPORTED? ☐ YES ☐ NO | IF YES, TO WHOM DID YOU REPORT IT? | | DATE REPORTED |
|---|---|---|---|
| WITNESSES? ☐ YES ☐ NO | IF YES, WITNESS #1 (NAME & PHONE) | WITNESS #2 (NAME & PHONE) | |
| IS THIS A NEW INJURY? ☐ YES ☐ NO | IF NO, PLEASE DESCRIBE THE ORIGINAL INJURY: | | DATE ORIG. INJURY |

**TREATMENT**

DID YOU RECEIVE TREATMENT? ☐ Reporting Only (No Treatment Needed) ☐ I declined treatment at the time ☐ Treatment was provided ☐ Treatment will be provided or sought

IF YOU RECEIVED TREATMENT, WHO PROVIDED IT? ☐ Self ☐ Employee Health Services ☐ Urgent Care ☐ Long Emergency Room ☐ Other (please specify on next line below)

| PROVIDER NAME (if name not above) | ADDRESS (if name is not above) | PHONE |
|---|---|---|
| DESCRIBE THE TREATMENT PROVIDED (Example: Cut was washed; antiseptic and bandage(s) were applied.): | | |

| DID THE PROVIDER CERTIFY YOU FOR DISABILITY BEYOND THE WORK-SHIFT? ☐ YES: Certified for disability beyond the work-shift (attach copy) ☐ NO | HAS THE PROVIDER RELEASED YOU FROM CARE? ☐ YES: Released ☐ NO: I will return for follow-up |
|---|---|

| By signing this form, the employee certifies that the information the employee has provided is true to the best of the employee's knowledge. | EMPLOYEE SIGNATURE ☐ *check here if digital signature* | DATE SIGNED |
|---|---|---|

INFORMATION PRACTICES NOTICE TO EMPLOYEE

The State of California Information Practices Act of 1977 (effective July 1, 1978) requires the University to provide the following information to:

Individuals who are asked to supply information about themselves:

The principal purpose for requesting the information on this form is to report the occurrence of a work-related injury or illness.

Furnishing all information on this form is mandatory. Failure to provide such information will delay or may even prevent completion of the action for which the form is being filled out. The information you provide may be released pursuant to applicable Federal or State law.

Individuals have the right to review their own records in accordance with University personnel policy and collective bargaining agreements. Information on applicable policies and agreements can be obtained from Campus, Laboratory, or Office of the President Staff and Academic Personnel Offices.

The official responsible for maintaining the information contained on this form is: the Workers' Compensation Claims Coordinator, Disability Management Services Unit, UCSF Human Resources Department, Box 0964, 3333 California Street, Suite 330, San Francisco, CA 94143