University of California Los Angeles

INCIDENT REPORT & REFERRAL FOR MEDICAL TREATMENT

Incident Reporting is required and ensures that there is a record on file with the employer. If an employee is injured or develops a job-related illness (developed gradually over time) as a result of their employment at UC, they must complete and submit this form. If the employee is unable to complete this form, the supervisor must complete it on their behalf. If an injury occurs, first aid may be the appropriate treatment. If you have any questions, please call your Campus Workers' Compensation representative at: Insurance & Risk Management (IRM) 310-794-6948 or Health System Human Resources (HS/HR) 310-794-0500.

EMPLOYEE: Return this form to your department after you have been seen at the Occupational Health Facility (OHF)

DEPARTMENT: within 1 day of the incident, Call 877-682-7778 24 hr report *or* Fax to 310-794-6957 *or* Email to wcreports@irm.ucla.edu

EMPLOYEE COMPLETES THIS SECTION:

Date of report: _____ *Check one* ☐ UCLA Campus ☐UCLA Medical Center ☐Santa Monica UCLA ☐ NPH/I

Sex: ☐ Male ☐ Female *Check one* ☐ Part-time ☐ Full-time ☐ Student ☐ Volunteer

Name **PRINT**: Last _____ First _____ SSN _____

Home Address: _____ City: _____ Zip: _____

Home Phone: _____ Work Hours (Shift): _____

Department: _____ Job Title: _____ Work phone: _____

Do you have other employment? ☐ Yes ☐ No If yes, where: _____

Date of Incident: _____Time of Incident: _____AM_PM Describe what you were doing: _____

_____

Describe all injured body parts (e.g. bruised elbow): _____

Were there witnesses? ☐ Yes ☐ No ☐ Unknown Name(s):_____

Is this a new injury? ☐ Yes ☐ No If "no", please indicate date of original injury: _____

INITIAL MEDICAL TREATMENT

☐ No medical treatment; reporting only ☐ Declined treatment at this time ☐ Treatment was/will be provided

Treatment was provided by: ☐ Self ☐ Occupational Health ☐ Emergency Room ☐ Other (please specify below)

Name: _____

Address: _____ Phone: _____

I, the injured employee, herein certify the information above is true and to best of my knowledge:

Date: _____ **Signature of Employee**: _____

SUPERVISOR/EMPLOYEE COMPLETES THIS SECTION:

Supervisor Name: _____ Email address_____

Work Phone: _____ Was the incident reported to you? ☐ Yes ☐ No Date reported: _____

Address/Bldg, name & room # where the incident occurred: _____

Describe how the employee was injured: _____

_____

Did employee lose time from work? ☐ Yes ☐ No ☐ Unknown First day off work due to injury: _____

Was the Employee paid for the full date of injury? ☐ Yes ☐ No Date Employee returned to work: _____

Was equipment/chemical involved? ☐ Yes ☐ No If answered "yes" what was the equipment/chemical:_____

_____

Was employee exposed to blood/bodily fluid other than his/her own? ☐ Yes ☐ No Source name/MR # _____

What action will be taken to prevent recurrence? _____

Date: _____ **Supervisor Signature:** _____ Title: _____

MEDICAL PROVIDER COMPLETES THIS SECTION: ☐ Occupational Health Facility (OHF) ☐ Emergency Medicine ☐ Other

Name/Address/Phone:_____

What treatment was provided for this injury (check one) ☐First Aid ☐Medical Treatment

Return To Work: Can Return immediately ☐ Yes ☐ No ☐ Full duty ☐Restrictions:_____

Date: _____ **Signature**: _____ Title: _____

REPORT ALL SERIOUS INJURIES TO EH&S HOTLINE 310-825-9797*Serious Injuries include death, loss of limb, burns, concussions, lacerations requiring stitches, crushes, fractures, and any hospitalization greater than 24-hours.*