## 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	S SECTION:	
Date of report:	Check one	JCLA Medical Center □Santa Monica UCLA □ NPH/I
Sex: ☐ Male ☐ Female	Check one ☐ Part-time ☐ Full-time	me 🗆 Student 🗀 Volunteer
Name PRINT: Last	First	SSN
Home Address:	City:	Zip:
Home Phone:	Work Hours	s (Shift):
Department:	Job Title:	Work phone:
Do you have other employment? $\square$	Yes Do If yes, where:	
Date of Incident:	_Time of Incident:AM_PM De	escribe what you were doing:
Describe all injured body parts (e.g.	bruised elbow):	
Were there witnesses? $\square$ Yes $\square$	No □ Unknown Name(s):	
Is this a new injury? $\square$ Yes $\square$ No	If "no", please indicate date of origina	al injury:
INITIAL MEDICAL TREATME	NT	
☐ No medical treatment; reporting of	only	his time
Treatment was provided by: $\square$ Self	☐ Occupational Health ☐ Em	nergency Room
Name:		
Address:		Phone:
I, the injured employee, herein cer	tify the information above is true and	d to best of my knowledge:
Date:	Signature of Employee:	
SUPERVISOR/EMPLOYEE COM	MPLETES THIS SECTION:	
Supervisor Name:	Email	address
Work Phone: Wa	as the incident reported to you? ☐ Yes	☐ No Date reported:
Address/Bldg, name & room # when	e the incident occurred:	
Describe how the employee was inju	ıred:	
Did employee lose time from work?	☐ Yes ☐ No ☐ Unknown First o	day off work due to injury:
Was the Employee paid for the full of	late of injury?   Yes   No Date Er	mployee returned to work:
Was equipment/chemical involved?	☐ Yes ☐ No If answered "yes" what	t was the equipment/chemical:
Was employee exposed to blood/boo	lily fluid other than his/her own?    Yes	s □ No Source name/MR #
What action will be taken to prevent	recurrence?	
Date:Supervise	or Signature:	Title:
MEDICAL PROVIDER COMPL	ETES THIS SECTION: ☐ Occupation	nal Health Facility (OHF) 🗆 Emergency Medicine 🗖 Ot
Name/Address/Phone:		
What treatment was provided	for this injury (check one) □Firs	st Aid □Medical Treatment
Return To Work: Can Return immed	fiately □ Yes □ No □ Full duty □Re	estrictions:
Date: Signate	are:	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.