## **UCD Employer's Report of Occupational Injury or Illness** UNIVERSITY POLICY REQUIRES THAT INDUSTRIAL INJURY/ILLNESS BE REPORTED TO WORKERS' COMPENSATION WITHIN 24 HOURS OF OCCURRENCE AND STATE REGULATIONS REQUIRE THAT ALL ACCIDENTS BE INVESTIGATED. In the event of a serious injury or hospitalization, call Workers' Compensation immediately at (530) 752-7243. This form must be completed in its entirety and mailed or faxed (530) 752-3439 to Workers' Compensation. Omission of information could result in a delay of benefits. **EMPLOYEE MUST COMPLETE THESE SECTIONS:** Employee's UCDavis ID #: **Employee Name:** Address: Home Phone: ( Date of Birth: City/State/Zip: Sex: ☐Female ☐Male Department/Location: Employee's Work Phone: ( ŏ Payroll Title/TC: Date of Hire: Annual Gross Salary: Supervisor's Name: Supervisor's Work Phone: ( Employee ( ) Volunteer ( ) Student-Employee ( ) )hours per day ) days per week ) total weekly hours Specific Injury/Illness/Exposure: Body Part(s) affected: Date of injury/illness: Location where injury or illness occurred: Others Injured? ☐Yes ☐No What equipment, materials or chemicals caused the injury/illness?: Who witnessed this injury? STAI Explain in detail how the injury occurred. Include specific activities/tasks performed at the time. ծ Medical Treatment provided by: Employee Health Services Sutter Davis Hospital ER Other: (Provide Name &Phone #) \_\_\_\_ EMPL Private Physician UC Davis Medical Center First Aid, no medical care needed. Employee Signature: Today's Date: EMPLOYER'S INVESTIGATION AND STATEMENT (EMPLOYER COMPLETES): After the investigation, explain in detail how the injury/illness occurred and the specific activity being performed: ծ ᆸ What was the injury, illness or exposure? CONTRIBUTING FACTORS AND ACTIVITIES INITIAL CAUSE PREVENTIVE ACTIONS ☐ Struck by or ☐ Ventilation issues☐ Ergonomic factors SUPERVISOR WILL: Equipment against object Equipment failure ☐ Develop/revise safety procedures and (indicate) Equipment unavailable update IIPP or Chem. Hyg. Plan **Employee** ☐ Physically not able to do work ☐ Improper equipment or ☐ Request ergonomic evaluation material used for job Employee fatigue Order new equipment ☐ Caught in/under/ Order new personal protective equipment Personal protective equipment Unbalanced or poor position between ☐ Not worn or motion Remove equipment from use and ☐ Fall / Slip / Trip ☐ Not readily available ☐ Incorrect procedures used for repair/replace ☐ Not adequate for the task task Schedule preventive maintenance or lifting Will retrain employee before task is ☐ Other unsafe practice ☐ Personal protective equipment Repetitive motion failure Assistance re-assigned. ☐ Chemical Training/Experience ☐ Difficult to perform task Perform on-site review of work activity, exposure Lack of training without help update job safety analysis. ☐ Body fluid Safety features or devices not ☐ Safety training provided, not Reconfigure work area exposure: readily available Communicate corrective actions to others followed \_Needle stick ☐ New task for employee or lack ☐ Assistive devices not used in job category. Sharps of experience Lack of policy/procedure ☐ Other ☐ Animal bite ☐ Animal (explain ☐ Other (explain) **Work Area** Animal (explain below) Other, Explain ☐ Work area set up improperly ☐ Inadequate lighting or noise Preventive actions will be completed by: issues Housekeeping issues ☐ Environmental factors Expected date of completion\_ (rain, wind, temp. etc) Use additional pages as needed SUPERVISOR'S OR MANAGER'S SIGNATURE: Date of Investigation: **DEPARTMENT HEAD'S SIGNATURE:** Date: