INJURY AND ILLNESS – INVESTIGATION REPORT

Supervisors: Report all serious or fatal on-the-job injuries to Cal/OSHA by calling 916-263-2800, within 8 hours of their occurrence. Serious injury or illness includes an amputation of a part of the body, disfigurement, or in-patient hospitalization for more than 24 hours for other than observation. Employers who fail to report serious or fatal on-the-job injuries to Cal/OSHA within 8 hours may be penalized a minimum of $5,000 and as much as $150,000. For all other injuries/illnesses, hand deliver or mail a Workers' Compensation Claim Form, "DWC 1" to the injured worker within 24 hours of your first knowledge. Make a copy of the "DWC 1" for Risk Management and notify them of injury immediately. Complete the "Injury and Illness Investigation Report" faxing a preliminary copy to Risk Management within 24 hours and the final version within 48 hours. Additional resources: i-Placer, V:\Risk Management.

Please check box below: **Due within 2 working days - Risk Management: 530.886.2600 - Fax: 530.886.2609**

☒ **Incident report only – not seeking Workers' Compensation benefits.** ☐ **First Aid only.**
☐ **Requesting Workers' Compensation benefits. Supervisor will provide the "Employees' Claim for Workers' Compensation Benefits" - "DWC -1" and retain a copy for Risk Management.**

Information about the Injured Worker

County Employee ☐ Inmate ☐ Work Release ☐ Volunteer ☐ Private Citizen ☐

1. Full Name: _____ Department: _____ Division: _____
2. Home Address: _____ City: _____ State: _____ Zip: _____
3. Date of Birth: _____ 4. Date Hired: _____ 5. Home Ph.#: _____
6. Male ☐ Female ☐ 7. Employee Number: _____ 8. Job Title: _____

Location Where Employee Based: ☐ Auburn ☐ Colfax ☐ Foresthill ☐ Lake Tahoe ☐ Other ☐ Lincoln ☐ Loomis ☐ Rocklin ☐ Roseville

Information about the doctor if seen for this incident

If necessary, direct or provide transportation for the injured worker to County-approved medical facilities posted on i-Placer and the V drive). In the event of a serious injury, the closest Emergency Room or Urgent Care Facility may be used. If an employee has already provided Risk Management written notice designating the primary care medical doctor for workers' compensation injuries, the employee may seek treatment from that doctor. Chiropractors may not be designated for this purpose.

9. Injured worker referred to which medical facility?: _____
   Facility: _____ Street: _____
   City: _____ State: _____ Zip: _____
10. Was First -Aid treatment provided? Yes ☐ No ☐
11. Was employee treated in an emergency room? Yes ☐ No ☐
12. Was employee hospitalized more than 24 hours? Yes ☐ No ☐ If yes, Cal/OSHA must be notified within 8 hours.

Information about the injury or illness

13. Date of injury: _____ 15. Time of event: _____ a.m. ☐ p.m. ☐
14. Time employee began work: _____ a.m. ☐ p.m. ☐ 16. Date / time reported: _____ a.m. ☐ p.m. ☐

Work Schedule – Days & Hours Worked: _____

Full Time ☐ Part Time ☐ Extra-Help ☐ Hours worked per Pay Period? _____

Restricted work provided?: Yes ☐ No ☐ Date and Time: _____ Directed to leave work? If yes,
Returned to Work?: Yes ☐ No ☐ Date and Time: _____ Date and Time: _____
Property damage? Yes ☐ No ☐ Third party involved? Yes ☐ No ☐ Actual lost work days: _____

Address where injured: _____

17. Case number from OSHA Log (N/A) _____ (Risk Management will transfer case # if applicable)

18. ***What was the employee doing just before the incident occurred?*** Describe the activity, as well as the tools, equipment, or material the employee was using. Be specific. Examples: "climbing a ladder while carrying roofing materials"; "spraying chlorine from hand sprayer"; "daily computer key-entry."

19. ***What happened?*** Tell us how the injury occurred. Examples: "When ladders slipped on wet floor, worker fell 20 feet"; "worker was sprayed with chlorine when gasket broke during replacement"; "Worker developed soreness in right and left wrists over time."

20. ***What was the injury or illness*****?** Tell us the part of the body that was affected and how it was affected; be more specific than "hurt", "pain", or "sore". Examples: "strained back"; "chemical burn, right hand"; "carpal tunnel syndrome".

21. ***What object or substance directly harmed the employee****?* Examples: "concrete floor", "chlorine"; "radial arm saw."
If this question does not apply, leave it blank.

22. **Cause of unsafe act** (if applicable)

23. **Corrective action** to prevent recurrence:

24. **If the employee died, when did the death occur?** Date and time of death:

25. **Names and phone number(s) of witness(es)** – attach any witness statements on a separate sheet of paper.

Completed by: (PRINT NAME) _____ Date: _____

Signature: _____ Phone: _____

Department head signature: _____

Attention: This form contains information relating to employee health and must be used in a manner that protects the confidentiality of employees to the extent possible while the information is being used for occupational safety and health purposes. See CCR Title 8 14300.29(b)(6)-(10)