

UCLA

INCIDENT REPORT & REFERRAL FOR MEDICAL TREATMENT

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

EMPLOYEE: RETURN THIS FORM TO YOUR DEPARTMENT AFTER YOU HAVE BEEN SEEN AT OHF

DEPARTMENT: FAX THIS FORM TO IRM 310 794-6957 within 1 day of the incident

EMPLOYEE COMPLETES THIS SECTION

Date of report: _____ Sex: Male Female *Check one* UCLA Campus UCLA Medical Center

Santa Monica UCLA NPH/I *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:** _____ **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 happened: _____

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 involved? Yes No If answered "yes" what was the equipment: _____

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: _____

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

Return To Work: Can Return immediately Yes No Full duty Restricted work

If no, date employee can return to work _____ Full duty Restricted work

Can return to work with these specific restrictions: _____

Estimated period of absence/restrictions: _____ to _____ Next appt: _____

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

A physician who treats an injured employee is required to file a 5021 ("Doctor's First Report of Injury") with the claims administrator for every work illness or injury, even first aid cases where there is no lost time from work.