



EMPLOYEE OCCUPATIONAL INCIDENT REPORT

- This report is to be completed by UCSD employees when an occupational (work-related) illness or incident occurs. Submittal of an Occupational Incident Report is not filing a claim for workers' compensation benefits. **FAX your report to (858) 246-0973.**
- The UCSD Workers' Compensation Office will provide the employee with a California State Workers' Compensation Claim Form (DWC-1), if the work-related injury incident requires medical treatment *beyond first aid or lost work days prescribed by a physician*. **Submittal of a completed DWC-1 claim form to the UCSD Workers' Compensation office activates a workers' compensation claim file.**
- If this **entire** Occupational Incident Report (Employee Page and Supervisor Page) is unable to be completed at the time of initial submittal, the **information in BOLD below is required to be completed for initial submittal.**
- If the employee is unable to complete an Occupational Incident Report, the supervisor must report the Incident on their behalf.
- If you have any questions, please call your Workers' Compensation representative at: (858) 534-4785 or 822-2979.

Last four digits of social security number: _____

Name (print): _____ Sex Male Female

Home Address: _____ City: _____ Zip: _____

Home Phone: _____ **Work Phone:** _____ **Mail Code:** _____

Department: _____ Job Title: _____

Supervisor Name: _____ **Phone No.** _____ **Mail Code:** _____

Employment Type: Full-time Part-time Regular Temporary Seasonal Volunteer

Do you have other employment? Yes No If so, where _____

Date of Incident: _____ **Time of Incident:** _____ **Time Shift Began:** _____

Address/Bldg, name & room # of incident: _____

State all parts of body and type of injuries involved (e.g. bruised right elbow)

Describe how incident occurred:

Did this injury/illness involve recombinant DNA? _____

Incident was reported to: _____ **Date:** _____

Do you require medical treatment for this injury?

No medical treatment Declined treatment at this time Treatment was/will be provided by:

Name (facility or physician): _____

If you do not have a Workers' Compensation Designation of Physician Form on file, you MUST seek treatment at one of the UCSD Occupational & Environmental Medicine Clinics (COEM) by calling 858-657-1600 (Campus location) or 619-471-9210 (Hillcrest location). For emergency care or treatment after COEM hours of operation, please go to the Thornton Hospital Emergency Room or the UCSD Hillcrest Medical Center Emergency Room.

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

Date: _____ **Signature of employee:** _____



SUPERVISOR OCCUPATIONAL INCIDENT REPORT

Supervisor of injured UCSD employee must complete and FAX this page, (858) 246-0973, to the Workers' Compensation Office in conjunction with either of the two reporting options utilized by the injured employee:

- o Option A: Employee reported incident via written Employee Occupational Incident Report, or
- o Option B: Employee reported incident via 1-800 Reporting Line: (877) 6UC-RPRT (877-682-7778)

Supervisor Name: _____	Work Phone: _____
Email: _____ @ucsd.edu	Department: _____

Name of injured employee: _____		
Date of Incident: _____	Time of Incident: _____	Job Title: _____
Where did this event happen? Address/Bldg, name & room # of incident: _____		

Did employee lose time from work after date of injury? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
If 'yes' last day worked _____	Date employee returned to work _____

State all parts of body and type of injuries involved (e.g. bruised right elbow) _____

Did this injury/illness involve recombinant DNA? _____
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Describe what happened:

Was there equipment involved? <input type="checkbox"/> Yes <input type="checkbox"/> No If you answered "yes" what was the equipment

What corrective actions have/will/should be made?

- **Important OSHA Requirement: Supervisors must immediately report all work-related deaths, catastrophes, and serious injuries or illnesses to the UCSD Workers' Compensation Office at (858) 534-2454.**
- The UCSD Workers' Compensation Office is required to report the above described injury or illness to Cal/OSHA **within 8 hours from the time of the incident**. Delays in reporting such injuries or illnesses to the Workers' Compensation Office in a timely manner could result in Cal/OSHA fines for your department.
- A serious injury or illness is one that requires inpatient hospitalization, or in which an employee suffers a loss of any member of the body or suffers any serious degree of permanent disfigurement.