



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) 534-5202.**
- 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 Doctor Designation for Workers Compensation form on file, you MUST only seek treatment @ Thornton Hospital Emergency Room, UCSD Hillcrest Medical Center Emergency Room or UCSD Occupational Medicine @ 619-471-9210.

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

Date: _____ Signature of employee: _____

