



SUPERVISOR OCCUPATIONAL INCIDENT REPORT

Supervisor of injured UCSD employee must complete and FAX this page to Workers' Compensation (858) 534-5202.

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? Yes No 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? _____

Describe what happened:

Was there equipment involved? Yes No If you answered "yes" what was the equipment

What corrective actions have/will/should be made?

Did the Employee seek medical treatment for this injury?

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

Name (facility or physician): _____

If the Employee does not have a Doctor Designation for Workers Compensation form on file, they MUST only seek treatment @ Thornton Hospital E R, UCSD Hillcrest Medical Center E R or UCSD Occupational Medicine @ 619-471-9210.

- **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.