University of California Los Angeles
INCIDENT REPORT & REFERRAL FOR MEDICAL TREATMENT

Incident Reporting is required and ensures that there is a record on file with the employer. If an employee is injured or develops a job-related illness (developed gradually over time) as a result of their employment at UC, they must complete and submit this form. If the employee is unable to complete this form, the supervisor must complete it on their behalf. If an injury occurs, first aid may be the appropriate treatment. If you have any questions, please call your Campus Workers' Compensation representative at: Insurance & Risk Management (IRM) 310-794-6948 or Health System Human Resources (HS/HR) 310-794-0500.

EMPLOYEE: Return this form to your department after you have been seen at the Occupational Health Facility (OHF)

DEPARTMENT: within 1 day of the incident, Call 877-682-7778 24 hr report *or* Fax to 310-794-6957 *or* Email to wcreports@irm.ucla.edu

EMPLOYEE COMPLETES THIS SECTION:

Date of report: ____________________ *Check one* ☐ UCLA Campus ☐UCLA Medical Center ☐Santa Monica UCLA ☐ NPH/I

Sex: ☐ Male ☐ Female *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: _______AM_PM 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 occurred: ____

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/chemical involved? ☐ Yes ☐ No If answered "yes" what was the equipment/chemical:_____________________________

____

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/Address/Phone:____

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

Return To Work: Can Return immediately ☐ Yes ☐ No ☐ Full duty ☐Restrictions:____

Date: __________________ **Signature**: ____ Title: _________________________________

REPORT ALL SERIOUS INJURIES TO EH&S HOTLINE 310-825-9797 *Serious Injuries include death, loss of limb, burns, concussions, lacerations requiring stitches, crushes, fractures, and any hospitalization greater than 24-hours.*