EMPLOYEE INCIDENT REPORT
(FOR REPORTING WORK-RELATED INJURIES & ILLNESSES)

Employees must complete this Incident Report when they sustain a work-related injury or illness.

Complete this Incident Report and return it to HR DMS at the fax number and address at the bottom of this form.

Incident Reporting ensures there is a record of the incident on file, and helps UCSF provide a safe work environment.

In filing this Incident Report you are not filing a workers' compensation claim. You file a claim by filling out a Workers' Compensation Claim Form (DWC 1). It is not necessary to fill out a Workers' Compensation Claim Form (DWC 1) to obtain first-aid treatment for a minor work-related injury. "First-Aid' means any one-time treatment, and any follow-up visit for the purpose of observation of minor scratches, cuts, burns, splinters, or other minor industrial injury, which do not ordinarily require medical care. This one-time treatment, and any follow-up visit for the purpose of observation, is considered first-aid even though provided by a physician or registered professional personnel.

If your physician indicates that your injury requires medical treatment beyond first-aid or certifies disability beyond your work-shift at the time of injury, HR DMS will provide you with a Workers' Compensation Claim Form (DWC 1) & Notice of Potential Eligibility.

EMPLOYEE

EMPLOYEE NAME (PLEASE PRINT)		LAST 4 DIGITS OF SSN	WORK PHONE	HOME PHONE
HOME STREET ADDRESS				
CITY, STATE, ZIP CODE		OCCUPATION/JOB TITLE		
DEPARTMENT NAME		SUPERVISOR NAME (PLEASE PRINT)		SUPERVISOR PHONE
DO YOU HAVE OTHER EMPLOYMENT? ___YES ___NO	IF YES, WHERE?			

INCIDENT

DATE OF INCIDENT	TIME OF INCIDENT	TIME BEGAN WORK:	TIME STOPPED WORK:	FINISHED SHIFT? ___YES ___NO
LOCATION OF INCIDENT (ADDRESS, BUILDING NAME, ROOM NUMBER, CITY, STATE, ZIP):				ON UC PROPERTY? ___YES ___NO

HOW DID THE INCIDENT OCCUR? DESCRIBE THE ACTIVITY AND ANY TOOLS, EQUIPMENT, OR MATERIAL YOUR WERE USING (Example: I was opening a box of paper using an exacto-knife. The exacto-knife slipped on the surface of the box, and cut the skin of my right index finger.):

LIST THE BODY PART(S) INJURED AND TYPE OF INJURY (Example: Skin cut on right index finger.):

HOW DO YOU THINK THIS TYPE OF INCIDENT CAN BE PREVENTED? (Example: By wearing protective gloves while using exacto-knife.):

INCIDENT REPORTED? ___YES ___NO	IF YES, TO WHOM DID YOU REPORT IT?	DATE REPORTED
WITNESSES? ___YES ___NO	IF YES, WITNESS #1 (NAME & PHONE)	WITNESS #2 (NAME & PHONE)
IS THIS A NEW INJURY? ___YES ___NO	IF NO, PLEASE DESCRIBE THE ORIGINAL INJURY:	DATE ORIG. INJURY

TREATMENT

DID YOU RECEIVE TREATMENT?
___Reporting Only (No Treatment Needed) ___I declined treatment at the time ___Treatment was provided ___Treatment will be provided or sought

IF YOU RECEIVED TREATMENT, WHO PROVIDED IT?
___Self ___Employee Health Services ___Urgent Care ___Long Emergency Room ___Other (please specify on next line below)

PROVIDER NAME (if name not above)	ADDRESS (if name is not above)	PHONE

DESCRIBE THE TREATMENT PROVIDED (Example: Cut was washed; antiseptic and bandage were applied.):

DID THE PROVIDER CERTIFY YOU FOR DISABILITY BEYOND THE WORK-SHIFT? ___NO ___YES: Certified for disability beyond the work-shift (attach copy)	HAS THE PROVIDER RELEASED YOU FROM CARE? ___YES: Released ___NO: I will return for follow-up

By signing this form, the employee certifies that the information the employee has provided is true to the best of the employee's knowledge.	EMPLOYEE SIGNATURE	DATE SIGNED

RETURN FORM TO: UCSF HR DMS, UCSF Box 0964, San Francisco, CA 94143-0964 FAX: (415) 476-2328 TEL: (415) 476-2621

INFORMATION PRACTICES NOTICE TO EMPLOYEE

The State of California Information Practices Act of 1977 (effective July 1, 1978) requires the University to provide the following information to individuals who are asked to supply information about themselves:

The principal purpose for requesting the information on this form is to report the occurrence of a work-related injury or illness.

Furnishing all information on this form is mandatory. Failure to provide such information will delay or may even prevent completion of the action for which the form is being filled out. The information you provide may be released pursuant to applicable Federal or State law.

Individuals have the right to review their own records in accordance with University personnel policy and collective bargaining agreements. Information on applicable policies and agreements can be obtained from Campus, Laboratory, or Office of the President Staff and Academic Personnel Offices.

The official responsible for maintaining the information contained on this form is: the Workers' Compensation Claims Coordinator, Disability Management Services Unit, UCSF Human Resources Department, 3333 California Street, Suite 330, San Francisco, CA 94143-0964 (UCSF Box 0964).