IIPP – Appendix D
January 2016

Please access the **Injury Reporting Procedure** page on the Safety Services website.

http://safetyservices.ucdavis.edu/article/injury-reporting-procedure

Complete the electronic **Employer's First Report** as soon as practicable.

UCD Employer's Report of Occupational Injury or Illness

UNIVERSITY POLICY REQUIRES THAT INDUSTRIAL INJURY/ILLNESS BE REPORTED TO WORKERS' COMPENSATION WITHIN 24 HOURS OF OCCURRENCE AND STATE REGULATIONS REQUIRE THAT ALL ACCIDENTS BE INVESTIGATED.
In the event of a serious injury or hospitalization, call Workers' Compensation immediately at (530) 752-7243. This form must be completed in its entirety and mailed or faxed (530) 752-3439 to Workers' Compensation. Omission of information could result in a delay of benefits.

EMPLOYEE MUST COMPLETE THESE SECTIONS:

EMPLOYEE DATA

Employee Name:		Employee's UCDavis ID #:
Address:		Home Phone: ( )
City/State/Zip:	Sex: ☐Female ☐Male	Date of Birth:
Department/Location:		Employee's Work Phone: ( )
Payroll Title/TC:	Date of Hire:	Annual Gross Salary: $
Supervisor's Name:		Supervisor's Work Phone: ( )
Employee ( ) Volunteer ( ) Student-Employee ( )	( )hours per day	( ) days per week ( ) total weekly hours

EMPLOYEE STATEMENT

Specific Injury/Illness/Exposure:	Body Part(s) affected:	Date of injury/illness:
Location where injury or illness occurred:		Others Injured? ☐Yes ☐No
What equipment, materials or chemicals caused the injury/illness? :		Who witnessed this injury?

Explain in detail how the injury occurred. Include specific activities/tasks performed at the time.

Medical Treatment provided by:
___Employee Health Services ___Sutter Davis Hospital ER Other: (Provide Name &Phone #) _____
___Private Physician ___UC Davis Medical Center _____
___First Aid, no medical care needed.

Employee Signature:	Today's Date:

EMPLOYER'S INVESTIGATION AND STATEMENT (EMPLOYER COMPLETES):

EMPLOYER

After the investigation, explain in detail how the injury/illness occurred and the specific activity being performed:

What was the injury, illness or exposure?

INITIAL CAUSE	CONTRIBUTING FACTORS AND ACTIVITIES		PREVENTIVE ACTIONS
☐ Struck by or against object (indicate) _____	**Equipment**	☐ Ventilation issues	**SUPERVISOR WILL:**
☐ Caught in/under/ between	☐ Equipment failure	☐ Ergonomic factors	☐ Develop/revise safety procedures and update IIPP or Chem. Hyg. Plan
☐ Fall / Slip / Trip	☐ Equipment unavailable	**Employee**	☐ Request ergonomic evaluation
☐ Material handling or lifting	☐ Improper equipment or material used for job	☐ Physically not able to do work	☐ Order new equipment
☐ Repetitive motion	**Personal protective equipment**	☐ Employee fatigue	☐ Order new personal protective equipment
☐ Chemical exposure	☐ Not worn	☐ Unbalanced or poor position or motion	☐ Remove equipment from use and repair/replace
☐ Body fluid exposure: __Needle stick __Sharps	☐ Not readily available	☐ Incorrect procedures used for task	☐ Schedule preventive maintenance
☐ Animal bite	☐ Not adequate for the task	☐ Other unsafe practice	☐ Will retrain employee before task is re-assigned.
☐ Other, Explain _____ _____ _____ _____ _____	☐ Personal protective equipment failure	**Assistance**	☐ Perform on-site review of work activity, update job safety analysis.
	Training/Experience	☐ Difficult to perform task without help	☐ Reconfigure work area
	☐ Lack of training	☐ Safety features or devices not readily available	☐ Communicate corrective actions to others in job category.
	☐ Safety training provided, not followed	☐ Assistive devices not used	☐ Other_____ _____
	☐ New task for employee or lack of experience	☐ **Lack of policy/procedure**	**Preventive actions will be completed by:**
	Work Area	☐ **Animal** (explain below)	Name_____
	☐ Work area set up improperly	☐ **Other** (explain) _____ _____ _____ _____	Expected date of completion_____
	☐ Inadequate lighting or noise issues		
	☐ Housekeeping issues		
	☐ Environmental factors (rain, wind, temp. etc)	**Use additional pages as needed**	

SUPERVISOR'S OR MANAGER'S SIGNATURE:	**Date of Investigation:**
DEPARTMENT HEAD'S SIGNATURE:	**Date:**

PLEASE NOTE: COMPLETING THIS FORM IS NOT AN ADMISSION OF UNIVERSITY LIABILITY 7/2011 ER: WC/H/MJB

IIPP-Appendix D
January 2016