University of California, Santa Barbara

INCIDENT REPORT

(For reporting work-related injuries/illnesses)

Workers' Compensation Program

CALL 1-877-682-7778 (toll free, 24 hours a day) to report the injury

This report is to be completed when an occupational injury, illness or incident occurs, or a job-related illness develops gradually (e.g., tendonitis) as a result of UCSB employment. *If the employee is unable to complete or sign the form, the supervisor or department representative must complete it on their behalf.* If you have any questions, please call the Workers' Compensation Office at 893-4440, or visit our website at http://www.workcomp.ucsb.edu/.

Incidents must be reported within 24 hours of knowledge **Fax completed form to:** Workers' Compensation **805-893-8521**	Note: Environmental Health & Safety (EH&S) must be notified immediately if any of the following occurs: worker fatality, inpatient hospitalization, loss of any body part (e.g., fingertip), or serious injury, at: **805-893-3194**

EMPLOYEE INFORMATION

Employee's Name (Last, First):		Employee ID # (9 digits):
Local Address, City, State, Zip:		
Home Phone:	Cell Phone:	Work Phone:

EMPLOYMENT INFORMATION

Department Name:		Job Title/Title Code:
Supervisor's Name:	Supervisor's Work Phone #:	Supervisor's Email Address:
Hours Worked: Hours per Day:	Days per Week:	Hours x Days = Total Hours per Week:
Employment Status (at time of injury) ☐Full Time	☐Part Time % Time _____	☐Limited From _____ to _____

Current Gross Wages/Salary:
$_____ Per: ☐Hour ☐Month ☐Other _____

Does employee have other employment? ☐Yes ☐No If "Yes", where: _____

INCIDENT INFORMATION

Date of Incident:	Time of Incident: _____ ☐am ☐pm	Time Began Work: _____ ☐am ☐pm	Time Stopped Work: _____ ☐am ☐pm

Location of Incident: *(Street, building, room)*:

What was the employee doing just before the incident occurred? (*Describe activity, tools, equipment, materials, etc.)*

What happened? (*Describe in detail how the incident occurred)*

List the body part(s) injured and type of injury: (*e.g., Right index finger, skin cut*)

Is this a new injury? ☐Yes ☐No If "No", please indicate date of original injury: _____

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

Signature of Employee:	Date:

SUPERVISOR COMPLETES THIS SECTION

Date Incident Reported:	Incident Reported To:

Did employee lose time from work? ☐Yes ☐No ☐Unknown – If "Yes", first day of lost time:_____

Description by supervisor. How did the incident occur? What was the activity and any tools, equipment, or materials employee was using?

Were there witnesses to this incident? ☐Unknown ☐No ☐Yes – If "yes", witness name(s) and phone number(s):

Did equipment malfunction cause the incident? ☐Yes ☐No
If "yes" remove equipment from use, tag for identification, secure it, and notify EH&S at 805-893-5288.

TYPE OF INCIDENT

☐Burns/Abrasions/Bites/Lacerations	☐Slip and Fall	☐Struck at/by	☐Exposure
☐Physical Movement/Sprain/Strain/Trip	☐Repetitive Motion	☐Stress	☐Vehicle

1. CONTRIBUTING CONDITIONS	**2. CONTRIBUTING BEHAVIORS**	**3. PREVENTIVE ACTION**
☐ Equipment or tool defect/failure	☐ Assistive device not used	Supervisor will:
☐ Equipment or tool unavailable	☐ Failure to get assistance	☐ Develop/revise safety procedures
☐ Ergonomic factors	☐ Improper body position/motion	☐ Maintain good housekeeping
☐ Lighting/temperature/ventilation	☐ Improper tool/equipment used	☐ Maintain tools/equipment
☐ Procedure lacking or unclear	☐ Inattention	☐ Post safety signs
☐ Training lacking or incomplete	☐ Lack of communication	☐ Provide protective equipment
☐ Uneven/slippery surface	☐ Procedure not followed	☐ Remove equipment from use
☐ Work area set-up/arrangement	☐ Protective equipment not worn	☐ Request ergonomic evaluation
☐ Work area clutter	☐ Rushing or hurried	☐ Request task safety analysis
☐ None	☐ Safety features of devices bypassed	☐ Schedule safety training
☐ Other (*list below*):	☐ Other (*list below*):	☐ Other (*list below*):

MEDICAL CARE

Was the employee referred for medical care?

☐**YES** ☐Occupational Med. Ctr. ☐Emergency Room ☐Other: _____
☐**NO** ☐Declined treatment at this time ☐Reporting only and/or departmental minimal first aid

TRANSITIONAL/MODIFIED WORK

In the event employee has work restrictions, the supervisor/department representative will be contacted to develop a temporary modified or alternate work plan. *For more information visit:* http://www.hr.ucsb.edu/disability/transitional-work-program

NOTE: COMPLETING THIS FORM IS *NOT* AN ADMISSION OF UNIVERSITY LIABILITY

Department Representative Who Completed This Form:	Date:
Email Address:	Phone Number:

FOR WORKERS' COMPENSATION USE ONLY

Notes:

Date updated in iVos: _____ *By:* _____

DWC Sent: ☐Yes ☐No *Copy to:* ☐Disability ☐Ergo ☐IRP ☐Other _____