University of California, Berkeley
Workers' Compensation

EMPLOYER'S REPORT OF INCIDENT

(for reporting work-related injuries/illnesses)

Incidents must be reported within 24 hours of knowledge **Fax completed form to:** **Disability Management Services** **(510) 642-6505**	**Note**: EH&S (510-642-3073) must be notified immediately if any of the following occurs: worker fatality, inpatient hospitalization, loss of any body part (e.g., fingertip), or possible permanent disfigurement

EMPLOYEE INFORMATION		
Employee's Name (Last Name, First Name):	Employee's Work Phone #: ( )	Employee ID # (9 digits): 01
Job Title:	Department Name:	Department Code:
Supervisor's Name:	Supervisor's Work Phone #: ( )	Supervisor's E-mail Address:

EMPLOYMENT INFORMATION		
Employment Status (Check applicable status at time of injury): ☐ Full-Time ☐ Part-Time % time ☐ Limited From: To:	Employee usually works: 0.00 hrs/day, 0 days/week = 0.00 total hrs/week	Does Employee go on Furlough? ☐ No ☐ Yes, Dates of Furlough (mm/dd/yy): From: To:
Gross Wages/Salary: $ per ☐ month ☐ hour ☐ annual	Shift Differential? ☐ No ☐ Yes, $ per hour	Does the employee receive a meal allowance? ☐ No ☐ Yes, $ per meal (*how many*) per day
Paid full wages for date of incident or last day worked? ☐ Yes ☐ No Number of hours of accrued leave (*sick leave, etc.)* used to pay full wages on this date: hours		If off work, date last worked (mm/dd/yy):
Unable to work for at least one full day after date of incident? ☐ Yes ☐ No	Salary being continued? ☐ Yes ☐ No	Date returned to work (mm/dd/yy):

INCIDENT INFORMATION				
Date of Incident:	Time of Incident: ☐ a.m. ☐ p.m.	Time Began Work: ☐ a.m. ☐ p.m.	Time Stopped Work: ☐ a.m. ☐ p.m	Date Employee Reported Incident:
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:*				

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What part(s) of the body were affected and how:

What object or substance directly harmed the employee:

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

Was there equipment involved in this incident? ☐Yes ☐No If "yes" what was the equipment?	Did equipment malfunction cause the incident? ☐Yes ☐No If "yes" remove equipment from use, tag it for identification, secure it, and notify EH&S (510-642-3073)

1. Contributing Conditions	2. Contributing Behaviors	3. Preventive Actions
☐ Duties or tasks not clear ☐ Equipment or tool defect/failure ☐ Equipment or tool unavailable ☐ Ergonomic factors ☐ Lighting/temperature/ventilation ☐ Procedure lacking or unclear ☐ Training lacking or incomplete ☐ Work area set-up/arrangement ☐ Work area clutter ☐ Unrecognized hazard: _____ ☐ Other: _____	☐ Assistive device not used ☐ Failure to get assistance ☐ Improper tool/equipment used ☐ Inattention to task ☐ Lack of communication ☐ Procedure not followed ☐ Protective equipment not worn ☐ Rushing or hurried ☐ Safety features of devices bypassed ☐ Unbalanced/poor body position/motion ☐ Other: _____	**Supervisor will**: ☐ Develop/revise safety procedures ☐ Maintain good housekeeping ☐ Maintain tools/equipment ☐ Post safety signs ☐ Perform job hazard analysis ☐ Perform task safety analysis ☐ Provide protective equipment ☐ Remove equipment from use ☐ Schedule safety training ☐ Other: See next line below

List any other actions that will be taken or control measures that will be put in place to prevent recurrence:

MEDICAL CARE

Where was the employee referred for medical care?

☐ Occupational Health Clinic (Tang Ctr) ☐ Urgent Care (Tang Ctr) ☐ Emergency Room ☐ Unknown ☐ Other:

Note: Completing this form is <u>not</u> an admission of University liability	Department Representative Who Completed This Form:	Date:
	E-Mail Address:	Phone Number:
	Campus Mail Address:	Mail Code:

If you have any questions, please contact Disability Management Services at (510) 643-7921.