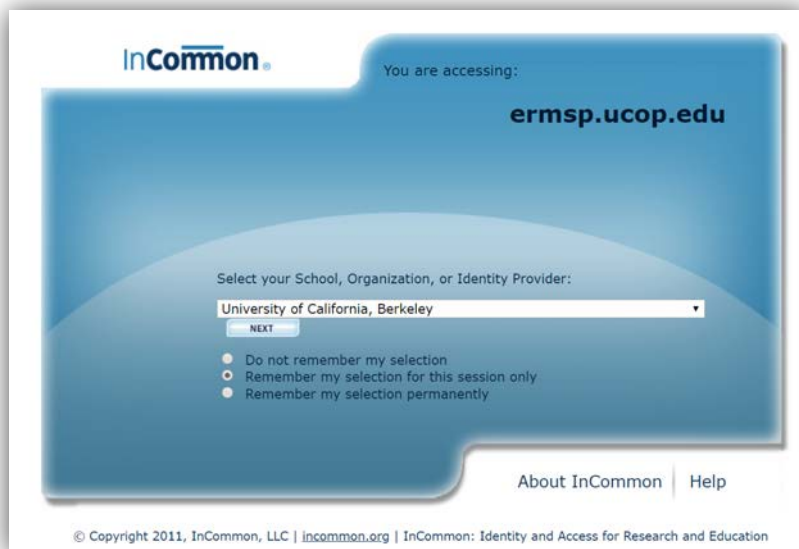


Instructions for Employer's First Report (EFR) (On-line reporting system)

Part 1: How to Report a Work-Related Injury or Illness

Go to: ehs.ucop.edu/efr



InCommon You are accessing: **ermosp.ucop.edu**

Select your School, Organization, or Identity Provider:

University of California, Berkeley

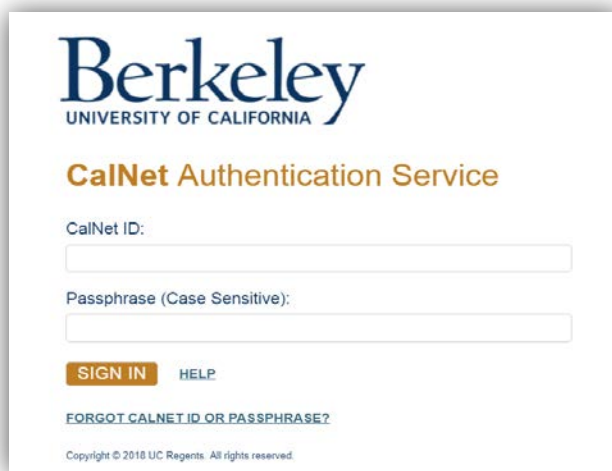
NEXT

- Do not remember my selection
- Remember my selection for this session only
- Remember my selection permanently

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- Scroll and select “University of California, Berkeley”
- Click “Next”



Berkeley
UNIVERSITY OF CALIFORNIA

CalNet Authentication Service

CalNet ID:

Passphrase (Case Sensitive):

SIGN IN [HELP](#)

[FORGOT CALNET ID OR PASSPHRASE?](#)

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- Sign-in with your CalNet ID
- Click “Sign In”

Personal

Create Claim - Enables you to report a new injury or illness incident for any University of California employee.



Create Claim

Report new injury or illness incident

My Claims - Allows you to view your personal claims.



My Claims

View personal claims

- Click “Create Claim”

Create Claim - Select Profile

- I am the Employee who experienced the occupational Injury/Illness.
- I am the Supervisor of the employee who experienced the occupational injury/illness.
- I am neither of the above.

[Continue to Incident Report](#)

[Cancel](#)

PLEASE NOTE: Completing this form is not an admission of university liability. It is a tool to gather all relevant facts so the incident may be investigated.

- Select who is entering this claim
- Click “Continue to Incident Report”

New Incident Report - Employee Information

Part 1 of 2

Please address/complete the highlighted fields and resubmit the form.


*Employee:	<input type="text" value="Search by Last Name, First Name"/>
Job Title:	<input type="text" value="Job title"/>
Email Address:	<input type="text" value="Email address"/>
Work Phone:	<input type="text" value="xxx-xxx-xxxx"/>
Home Phone:	<input type="text" value="xxx-xxx-xxxx"/>
Home Address 1:	<input type="text" value="Address line 1"/>
Home Address 2:	<input type="text" value="Address line 2"/>
City:	<input type="text" value="City"/>
State:	<input type="text" value="CA"/>
Postal code:	<input type="text" value="Postal code"/>

All fields marked with an (*) must be completed

- Enter as much information as possible
- Employee name box is an active field. Begin typing last name, then select name after it appears
- Once employee name is entered, some of the other boxes will autofill

Continued...

Employment Type: Choose one of the following... ▾

Date Of Birth: mm/dd/yyyy 

*Gender: Female Male Other

Marital Status: Choose one of the following... ▾

Employee Work Hours: hours/day hours/day days/week days/week

Supervisor: Search by Last Name, First Name
If you are unable to locate your supervisor, please select another supervisor from your department.

Supervisor's Email Address: Enter an email address

*Supervisor's Phone: xxx-xxx-xxxx

[Continue to Part 2 →](#) [Cancel](#)

- Continue to enter as much information as possible
- Enter supervisor information. If you are the supervisor, it will autofill your name and email.
- Add supervisor's phone number.
- Click "Continue to Part 2"

New Incident Report - Employee Information

Part 2 of 2

Employer Knowledge Date:

mm/dd/yyyy



Date when employer first became aware of the incident.

*Date of injury or onset of illness:

mm/dd/yyyy



Time of injury or illness:

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--

please enter best guess

Building in or near where the incident happened (if applicable):

Enter the first few letters of a building name to search.

*Location where injury or illness occurred:

- Enter as much information as possible
- Building field is active. Begin typing building name, then select name after it appears
- For location, be specific as possible. For example, “*On Campanile Way in front of the stairs to Valley Life Science Building (southeast corner)*”

Continued...

*Were others injured? Yes No

*BioHazard Material Exposure? Yes No
(ie. Needle Stick, Animal Bite, Infectious Exposure)

*Chemical Exposure? Yes No

*Injury/Illness and Body Parts:

If this injury was caused by a trip or fall, was the employee wearing shoes provided by the Slip-Resistant Footwear Program? Yes No

What equipment, materials or chemicals were involved in the injury or illness?

*Explain in detail how the injury/illness occurred. Be specific about activities and tasks being performed at the time of the injury or onset of illness:

- Continue to enter as much information as possible
- Specific details as to the incident and how the injury occurred are especially important

Continued...

- For example, instead of writing “*employee cut finger opening box*” be specific with all details and write, “*employee cut tip of index finger on left hand while opening a box of paper using a box cutter*”

Continued...

Who witnessed the injury or circumstances causing the illness. Please list first and last name(s):

*Medical Treatment:

- Outpatient Treatment by Clinic, Doctors' Office, or Hospital
- Emergency Room
- Overnight Inpatient Hospitalization
- First Aid, no medical care

← Return to previous Save

- Continue to enter as much information as possible
- After all available information has been entered, click “Save”

- You have now created a claim
- You do not need to contact the Disability Management office (workers' compensation) unless you have a question or concern
- Questions? Contact Be Well at Work- Disability Management (643-7921)

- If you are a supervisor or responsible for incident investigation, please complete the “Employer Investigation” section in the EFR
- For assistance, please see the Employer Investigation Instructions