Attention: This form contains information relating to employee health and must be used in a manner the protects the confidentiality of employees to the extent possible while the information is being used for occupational safety and health purposes. See CCR Title 8 14300.29(b)(6)-(10)

UNIVERSITY OF CALIFORNIA SANTA CRUZ

Supervisor's Incident Investigation & Report of Occupational Injury

TO COMPLY WITH WORKERS' COMPENSATION LAW
COMPLETE AND FAX BOTH SIDES TO RISK SERVICES IMMEDIATELY (831) 459-3268

Please check one:

☐ **Workers' Compensation Claim—**Employee reported a job-related injury or illness and requested medical attention or first aid from a healthcare provider or lost time from the job due to a work-related injury. Supervisor's report must be completed and submitted to Risk Services within 24 hours of supervisor's knowledge of injury. If injuries are serious or fatal, report by telephone to Risk Services (831-459-2850/ -5154/ -3261) then complete this form.

☐ **Information Only Report—**To document facts about reported occupational injuries, illnesses, exposures and non-injury mishaps where medical treatment is not currently warranted but may become necessary at a future time.

EMPLOYEE INFORMATION

EMPLOYEE NAME			EMPLOYEE I.D. NUMBER
HOME ADDRESS	CITY		HOME PHONE
STATE ZIP	GENDER ☐ MALE ☐ FEMALE	DATE OF BIRTH (mm/dd/yy)	DATE OF HIRE (mm/dd/yy)
REGULAR JOB TITLE		JOB TITLE CODE	WORK PHONE
SCHEDULED HOURS PER WEEK ☐ 40 ☐ ________	EMPLOYMENT STATUS CAREER % ________ CASUAL % ________		JOB END DATE (mm/dd/yy)
TIME BEGAN WORK AM PM	PAY RATE AT TIME OF INJURY $ ____________ /MO. OR $ ____________ /HR.		WAS EMPLOYEE PAID FULL WAGES FOR DAY OF INJURY? ☐ YES ☐ NO
DID EMPLOYEE LOSE AT LEAST ONE FULL DAY OF WORK BEYOND DAY OF INJURY ☐ YES ☐ NO	IF YES, INDICATE DATE LAST WORKED (mm/dd/yy)		IF RETURNED TO WORK, INDICATE DATE RETURNED (mm/dd/yy)

DETAILS OF INJURY, ILLNESS, EXPOSURE OR INCIDENT

DATE OF INJURY, ILLNESS, EXPOSURE OR INCIDENT (mm/dd/yy)		TIME OF INJURY, ILLNESS, EXPOSURE OR INCIDENT (am/pm)
SPECIFIC INJURY/ILLNESS AND PART OF BODY AFFECTED (e.g. pain on movement—both wrists)		MEDICAL DIAGNOSIS IF AVAILABLE (e.g. tendonitis)
IF YES, WAS EMPLOYEE SEEN BY: ☐ DOMINICAN OCCUP. HEALTH CENTER ☐ DOMINICAN EMERGENCY DEPT. ☐ PRE-DESIGNATED PERSONAL PHYSICIAN (specify below) ☐ OTHER UCSC-DESIGNATED FACILITY (specify below) DR. NAME: DR. ADDRESS:		
DID EMPLOYEE RECEIVE MEDICAL EVALUATION/ AND/OR TREATMENT? ☐ YES ☐ NO	DATE OF EMPLOYER'S FIRST KNOWLEDGE/NOTICE OF INJURY/ILLNESS (mm/dd/yy)	DATE CLAIM FORM WAS PROVIDED TO EMPLOYEE (mm/dd/yy)
WAS EMPLOYEE HOSPITALIZED OVERNIGHT AS AN INPATIENT? ☐ YES ☐ NO	IF YES, WHERE?	DATE OF DEATH (IF APPLICABLE)

INVESTIGATION OF INJURY, ILLNESS, EXPOSURE OR INCIDENT

LOCATION OF OCCURRENCE (specify location, building, room number, etc.)		
ON UCSC PREMISES? ☐ YES ☐ NO	DEPARTMENT WHERE EVENT OCCURRED	WERE OTHER EMPLOYEES INJURED IN THIS EVENT? ☐ YES ☐ NO
EQUIPMENT, TOOLS, MATERIALS OR CHEMICALS THE EMPLOYEE WAS USING WHEN EVENT OR EXPOSURE OCCURRED; (e.g. computer keyboard and mouse, passenger van, file boxes, etc.)		
DESCRIBE THE SPECIFIC ACTIVITY EMPLOYEE WAS PERFORMING WHEN EVENT OR EXPOSURE OCCURRED; (e.g. data entry, driving/making left turn, descending stairs.)		
DESCRIBE THE SEQUENCE OF EVENTS LEADING UP TO THE INJURY. SPECIFY THE OBJECT OR SUBSTANCE THAT DIRECTLY PRODUCED THE INJURY/ILLNESS; (e.g. special project required extensive data entry last 6 weeks. Worker performed continuous data entry for 8 hours/day without alternate work periods and, despite increasing pain, did not report until 4 weeks after symptoms began. Pain is associated with keyboard use) USE SEPARATE SHEET IF NECESSARY.		
WAS THIS INJURY/ILLNESS/INCIDENT CAUSED BY AN UNSAFE ACT? ☐ YES ☐ NO	WAS THIS INJURY/ILLNESS/INCIDENT CAUSED BY AN UNSAFE CONDITION? ☐ YES ☐ NO	

CONTINUED ON REVERSE SIDE

DETAILS OF INCIDENTS CAUSED BY AN UNSAFE ACT

IF INCIDENT WAS CAUSED BY AN UNSAFE ACT: IS THERE A WRITTEN OPERATING PROCEDURE FOR THIS ACTIVITY? ☐ YES ☐ NO

IF NOT, IS THERE AN UNWRITTEN OPERATING PROCEDURE FOR THIS ACTIVITY? ☐ YES ☐ NO

WAS EMPLOYEE TRAINED IN THIS PROCEDURE? ☐ YES ☐ NO ☐ NO STANDARD PROCEDURE

DOCUMENTED TRAINING DATE: (mm/dd/yy)

DID EMPLOYEE FOLLOW THE PROCEDURE? ☐ YES ☐ NO ☐ NO STANDARD PROCEDURE

IF EMPLOYEE DID NOT FOLLOW PROCEDURE, WHY NOT? *(COULD NOT* OR *WOULD NOT?)* EXPLAIN; (e.g. employee did not have identified alternative work; or employee thought they could work faster without alternative work periods)

DESCRIBE IN DETAIL THE CORRECTIVE ACTION(S) TAKEN *(TRAINING* OR *PROGRESSIVE DISCIPLINE):*

IF THE EMPLOYEE WAS PREVIOUSLY TRAINED, DID NOT FOLLOW PROPER PROCEDURES AND WAS NOT DISCIPLINED PLEASE EXPLAIN WHY

HAVE OTHER ACCIDENTS OCCURRED WITH THE SAME PROCESS OR PROCEDURE? ☐ YES ☐ NO ☐ DON'T KNOW

DOES THE TRAINING NEED TO BE CHANGED TO BETTER ADDRESS THIS HAZARD? ☐ YES ☐ NO

IF TRAINING NEEDS TO BE CHANGED, IDENTIFY THE CHANGES NEEDED

DOES THE WORK PRACTICE OR WRITTEN OPERATING PROCEDURE NEED TO BE CHANGED TO BETTER ADDRESS THIS HAZARD? ☐ YES ☐ NO

IF YES, SUGGEST THE CHANGES NEEDED

ARE ALL FACTS PROPERLY DOCUMENTED? ☐ YES ☐ NO

DETAILS OF INCIDENTS CAUSED BY AN UNSAFE CONDITION

IS THE RESPONSIBILITY FOR SAFETY INSPECTIONS IN THIS AREA ASSIGNED? ☐ YES ☐ NO

IF YES, TO WHOM?

HAVE SITE SAFETY INSPECTIONS BEEN CONDUCTED ACCORDING TO A SCHEDULE? ☐ YES ☐ NO

DATE OF LAST SITE SAFETY INSPECTION (mm/dd/yy)

IF NO DOCUMENTED SITE SAFETY INSPECTIONS HAVE BEEN CONDUCTED, WHY NOT?

IF SITE SAFETY INSPECTIONS WERE CONDUCTED, WAS THE INSPECTOR FAMILIAR WITH THIS POTENTIAL WORKPLACE HAZARD? ☐ YES ☐ NO

DID THIS UNSAFE CONDITION EXIST AT THE TIME OF THE LAST INSPECTION? ☐ YES ☐ NO

IF DEFECTIVE EQUIPMENT WAS INVOLVED, HAS IT BEEN TAKEN OUT OF SERVICE? ☐ YES ☐ NO

HAS THE HAZARDOUS CONDITION BEEN PREVIOUSLY IDENTIFIED? ☐ YES ☐ NO IF YES, DATE OF IDENTIFICATION:

IF THE HAZARD WAS PREVIOUSLY IDENTIFIED, WERE ACTIONS TAKEN TO CORRECT OR MITIGATE THE HAZARD? ☐ YES ☐ NO

IF YES, DATE AND NATURE OF CORRECTION OR MITIGATION STEPS TAKEN

IF NO, EXPLAIN WHY NO ACTION WAS TAKEN

DOES THE WORKPLACE INSPECTION FORM NEED TO BE CHANGED TO DETECT THE HAZARD CAUSING THIS INCIDENT? ☐ YES ☐ NO

IF YES, NATURE OF THE CHANGES NEEDED

SUPERVISOR'S INFORMATION

WHAT ACTION(S) ARE YOU COMMITTING TO TAKE AS A SUPERVISOR TO PREVENT FUTURE INCIDENTS OF THIS TYPE? ☐ CORRECT UNSAFE CONDITION
☐ RETRAIN EMPLOYEE(S) ☐ DISCIPLINE EMPLOYEE ☐ IMPLEMENT/REVISE OPERATING PROCEDURE ☐ REVISE TRAINING PROGRAM ☐ MODIFY/UPGRADE WORK TOOLS
☐ COMMUNICATE FACTS AND PREVENTION TIPS WITH OTHER EMPLOYEES ☐ CONDUCT MORE FREQUENT SAFETY CHECKS ☐ OTHER (specify)

SUPERVISOR'S NAME	SUPERVISOR'S TITLE	DEPARTMENT	WORK TELEPHONE

SUPERVISOR'S SIGNATURE	DATE

Distribution: Copy to Supervisor, Copy to Human Resources, Original to Office of Risk Services, H-Barn, via FAX (831) 459-3268 and mail. FAX with all available information within 24 hours. OK to fax partial until investigation is complete. Call (831) 459-2850 for assistance.