**Incident and Investigation Report**

FOR REPORTING WORK-RELATED INJURIES & ILLNESSES

**Instructions:** Complete this form when a work-related injury or illness occurs or develops as a result of employment at the University of California Riverside (UCR). Please submit this form within 24 hours of the date of incident to *HR Workplace Health & Wellness – Workers’ Compensation* by **Fax (951) 827-2192** or **Email** workerscomp@ucr.edu. If an employee is unable to complete the form, the supervisor must complete on his/her behalf.

**Note: If an accident results in an employee to be hospitalized, other than for observation, for 24 hours or more, or a loss of a limb (amputation) or loss of life, notify Workers’ Compensation Office and EH & S immediately. EH & S must report such accidents to OSHA within 8 hours of the event.**

**Notice about Workers’ Compensation:** Incident Reporting ensures there is a record on file with the employer. Filing of an incident report is not a filing of a workers’ compensation claim. An employee retains his/her right to file a workers’ compensation claim at a later date. Contact *HR Workplace Health & Wellness – Workers’ Compensation* for more information.

**Employee Statement**

(Please Print)

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| **Employee** | Employee Name: | Employee ID | Phone (Work) |
| Address (Home): | Phone (Home) |
| Job Title: | Work Hours (Schedule): |
| Department: | Supervisor Name: | Supervisor Phone (Work): |
| do you have other employment? 🞏 **Yes**  🞏 **No** | If Yes, Where? |

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| **Incident** | Date of Incident: | 🞏 AM | Time Work Began:\_\_\_\_\_\_:\_\_\_\_\_\_\_ | Time Work Stopped:\_\_\_\_\_\_:\_\_\_\_\_\_\_ |
| \_\_\_\_\_\_\_\_\_\_\_\_ / \_\_\_\_\_\_\_\_\_\_\_\_ / \_\_\_\_\_\_\_\_\_\_\_\_ at \_\_\_\_\_\_\_\_\_:\_\_\_\_\_\_\_\_\_\_ | 🞏 PM |
| Location of Incident (Building Name, Room Number, etc.) |
| **Description**. How did the incident occur? What was the activity and any tools, equipment, or materials you were using?*(Example: I was opening a box of paper using a razor blade. The razor blade slipped on the surface of the box, and cut my right index finger)* |
| List the body part(s) injured and type of injury.*(Example: Right index finger skin cut)* |
| Did you report the incident? 🞏 **Yes**  🞏 **No** | If Yes, to whom? | Date Reported: |
| Were there Witnesses?🞏 **Yes**  🞏 **No**  🞏 **Unknown** | If Yes, Witness name(s): |
| Is this a new injury?🞏 **Yes**  🞏 **No**   | If No, what is the date of original injury: |

|  |  |
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| **Treatment** | Did you receive medical treatment? 🞏 **Yes**  🞏 **No** (skip this section) |
| If Yes, list Medical Provider Name and address |

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| **Certification.** *By signing this form the employee certifies that the information provided is true and correct to the best of the employee’s knowledge.* | Employee Signature | Date: |

Supervisor Statement
(Please Print)

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| **Supervisor****Review** | **Description by Supervisor**. How did the incident occur according to your findings? What was the activity and any tools, equipment, or materials employee was using? *(Example: Employee was opening a box of paper using a razor blade. Employee was distracted and the razor blade slipped on the surface of the box, cutting the employee’s right index finger)* |
| **Type of Injury (or Direct Cause)**[ ] Animal bite [ ] Burn[ ]  Chemical exposure [ ]  Caught in / under / between | [ ]  Cut or Wound[ ]  Fall / Slip / Trip[ ]  Lifting, pushing, pulling,  or other material handling activities | [ ]  Puncture and/or body fluid exposure  \_\_Needle stick \_\_Sharps[ ]  Repetitive motion (Ergonomic)[ ]  Struck by or against object[ ]  Other (please describe): |
| Did the employee lose time from work? 🞏 **Yes**  🞏 **No**  | If Yes, what was the first day of lost time? |
| Was any equipment involved? 🞏 **Yes**  🞏 **No** | If Yes, what was the equipment? |

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| **Root Causes****Analysis** | 1. **Employee** Performance
 | [ ]  Lack of practice[ ]  Rush[ ]  Fatigue | [ ]  Physically not capable[ ]  Improper risk taken and/or poor judgment[ ]  Lack of skill, knowledge, or  hazard awareness | [ ]  Other (please describe): |
| 1. **Environment** *and Work Area*
 | [ ]  Uneven surface [ ]  Slippery surface[ ]  Insufficient lighting | [ ]  Noisy environment [ ]  Poor housekeeping[ ]  Improper work area setup | [ ]  Other (please describe): |
| 1. **Equipment and Tools***(including PPE)*
 | [ ]  Failure or Malfunction [ ]  Improper use of equipment/ (i.e., wrong type selected for job) | [ ]  Not available [ ]  Insufficient equipment/tool (example: not enough machine guarding) | [ ]  Other (please describe): |
| 1. **Management** *Systems and Processes*
 | [ ]  Lack of policies/procedures[ ]  No enforcement[ ]  Lack of communication[ ]  Training was not provided | [ ]  Safety was not considered during equipment purchasing, work setup, or project development [ ]  Training was insufficient / inadequate | [ ]  Inadequate manpower (not enough staff)[ ]  Other (please describe): |

**Instructions**

List the root cause(s), or reason(s) why the incident occurred. For each root cause, make sure to identify a preventive action (things that supervisor or employee will do to prevent the incident from occurring again).

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| **Preventive Action****plan** | **Root Causes***identified from Analysis* | **Preventive Action***To be taken for* ***each*** *root cause* | **Individual***Assigned To* | **Target Date** |
| 1.  |  |  |  |
| 2. |  |  |  |
| 3. |  |  |  |
| 4. |  |  |  |
| 5.  |  |  |  |

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| **Supervisor Certification.** *By signing this form the supervisor (or designee) certifies that the information provided is true and correct to the best of the supervisor’s (or designee’s) knowledge.* | Supervisor Signature (or designee) | Date: |

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| Send this completed form to ***Human Resources Workplace Health & Wellness – Workers’ Compensation***  | **Fax to**: (951) 827-2192 | **Mail to:** 900 University Ave Riverside, CA 92521 | **Email to:** workerscomp@ucr.edu  |