**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](mailto: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**

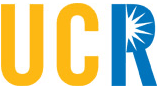
(Please Print)

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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](mailto:workerscomp@ucr.edu) |