UCLA Health

INCIDENT REPORT & REFERRAL FOR MEDICAL TREATMENT

Incident Reporting ensures there is a record on file with the employer. If an employee is injured or develops a job-related illness (developed gradually over a period of time) as a result of their employment at UC, they must complete and submit the "Incident Report". If the employee is unable to complete the form, the supervisor must complete on their behalf. If an injury occurs, first aid* may be the appropriate treatment. If you have any questions, please call your Workers' Compensation representative at:

Health System Human Resources Workers' Comp (310) 794-0500 or Campus IRM (310) 794-6948

COMPLETE ALL SECTIONS OF THIS FORM. PLEASE TAKE COMPLETED FORM TO OCCUPATIONAL HEALTH OR UCLA EMERGENCY MEDICINE FOR MEDICAL TREATMENT

DEPARTMENT: IMMEDIATELY FAX THIS FORM TO:

MEDICAL CENTER HEALTH SYSTEM HR (310) 794-4337
CAMPUS IRM (310) 794-6957

EMPLOYEE COMPLETES THIS SECTION:

Date of Report: _____ Sex: ☐ Male ☐ Female

Check One: ☐ Part-time ☐ Full-time ☐ Student ☐ Volunteer

Check One: ☐ UCLA Campus ☐ Ronald Reagan UCLA Medical Center ☐ Santa Monica UCLA ☐ NPH/I

Check one: ☐ 8-hr shift ☐ 10-hr shift ☐ 12-hr shift ☐ Other: _____

Date of Birth: _____

Name _____ _____ _____

(Please Print) Last First SSN/Employee ID #

Home Address: _____ City: _____ Zip: _____

Home Phone: _____ Work Hours (Shift): _____

Department: _____ Job Title: _____ Work Phone: _____

Do you have other employment? ☐ Yes ☐ No If yes, where: _____

Date of Incident: _____ Time of Incident: _____ AM/PM _____

Describe what you were doing: _____

_____

_____

Describe all injured body parts (e.g., bruised elbow): _____

_____

_____

Were there witnesses? ☐ Yes ☐ No ☐ Unknown

Names(s): _____

Is this a new injury? ☐ Yes ☐ No If "no" please indicate date of original injury: _____

INITIAL MEDICAL TREATMENT:

☐ No medical treatment-reporting only ☐ Declined treatment at this time ☐ Treatment was/will be provided

Treatment was provided by: ☐ Self ☐ Occupational Health ☐ Emergency Room

☐ Other (please specify below)

Name: _____

Address: _____ Phone: _____

Distribution: Medical Center ☐ 1. Occupational Health ☐ 2. Health System Human Resources ☐ 3. Sedgwick CMS ☐ 4. Employee's File

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EMPLOYEE: If you have been treated by a medical provider, it is your responsibility to obtain a work status slip from the medical provider and turn it in to your supervisor/department immediately.

I, the injured employee, herein certify the information above is true and to the best of my knowledge.

Date: _____ **Signature of Employee:** _____

SUPERVISOR/EMPLOYEE COMPLETES THIS SECTION:

Supervisor Name: _____ E-Mail Address: _____

Work Phone: _____ Was the incident reported to you? ☐ Yes ☐ No Date Reported: _____

Address/Bldg. name & room # where the incident happened: _____

Describe how the employee was injured: _____

_____

_____

Did the employee lose a full day from work? ☐ Yes ☐ No ☐ Unknown

First day off work due to injury: _____

Was the Employee paid for the full date of injury? ☐ Yes ☐ No Last date worked: _____

Was the Employee paid for the full day of last date worked? ☐ Yes ☐ No

Has the Employee returned to work? ☐ Yes ☐ No ☐ Unknown Date Employee returned to work: _____

Was equipment involved? ☐ Yes ☐ No If answered "yes" what was the equipment? _____

Was Employee exposed to blood/bodily fluid other than his/her own? ☐ Yes ☐ No

Source name/MR # _____

What action will be taken to prevent recurrence? _____

_____

_____

Other Comments: _____

_____

_____

SUPERVISOR: If your employee is treated by a medical provider, please ensure you receive a current work status slip from your employee throughout the course of treatment.

Date: _____ **Supervisor Signature:** _____ **Title:** _____

*A physician who treats an injured employee is required to file a 5021 ("Doctor's First Report of Injury") with the claims administrator for every work illness or injury, even first aid cases where there is no lost time from work.

FILING OF THIS FORM IS NOT AN ADMISSION OF LIABILITY