UCLA Health System

INCIDENT REPORT & REFERRAL FOR MEDICAL TREATMENT

Incident Reporting is required and ensures that there is a record on file with the employer. If an employee is injured or develops a job-related illness (developed gradually over time) as a result of their employment at UC, they must complete and submit this form. If the employee is unable to complete this form, the supervisor must complete it on their behalf. If an injury occurs, first aid may be the appropriate treatment. If you have any questions, please call your Campus Workers' Compensation representative at: Health System Human Resources 310-794-0500 or Insurance & Risk Management (IRM) 310-794-6948.
EMPLOYEE: 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		**UCLA OHF**	**(310) 206-4585**
Santa Monica UCLA		**Health System HR**	**(310) 794-3337**
UCLA Campus		**Employee Health**	**(310) 828-0497**
		IRM	**(310) 794-6957**

EMPLOYEE COMPLETES THIS SECTION:

Date of report:_____ *Check one* ☐ UCLA Campus ☐ UCLA Medical Center ☐ Santa Monica UCLA ☐ NPH/I

Sex: ☐ Male ☐ Female *Check one* ☐ Part-time ☐ Full-time ☐ Student ☐ Volunteer Employee ID: _____

Name **PRINT**: Last_____ First_____ SSN _____

Home Address:_____ City:_____ Zip: _____

Home Phone:_____ Work Hours (Shift):_____

Department _____ Job Title _____ Work Phone: _____

Do you have any 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 Name(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: _____

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

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

SUPERVISOR/EMPLOYEE COMPLETES THIS SECTION:

Supervisor Name:_____ Email address _____

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

Address/Bldg, name & room # where the incident occurred: _____

Describe how the employee was injured:_____

_____

Did employee lose time from work? ☐ Yes ☐ No ☐ Unknown First day off work due to injury: _____

Was the Employee paid for the full date of injury? ☐ Yes ☐ No Date Employee returned to work: _____

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

_____

What 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? _____

_____

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:_____ 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 THIS FORM IS NOT AN ADMISSION OF LIABILITY

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

PRINT CLEAR

State of California
Department of Industrial Relations
DIVISION OF WORKERS' COMPENSATION

Estado de California
Departamento de Relaciones Industriales
DIVISION DE COMPENSACIÓN AL TRABAJADOR

WORKERS' COMPENSATION CLAIM FORM (DWC 1)

PETITION DEL EMPLEADO PARA DE COMPENSACIÓN DEL TRABAJADOR (DWC 1)

Employee: Complete the **"Employee"** section and give the form to your employer. Keep a copy and mark it "**Employee's Temporary Receipt"** until you receive the signed and dated copy from your employer. You may call the Division of Workers' Compensation and hear recorded information at **(800) 736-7401.** An explanation of workers' compensation benefits is included in the Notice of Potential Eligibility, which is the cover sheet of this form. Detach and save this notice for future reference.

You should also have received a pamphlet from your employer describing workers' compensation benefits and the procedures to obtain them. You may receive written notices from your employer or its claims administrator about your claim. If your claims administrator offers to send you notices electronically, and you agree to receive these notices only by email, please provide your email address below and check the appropriate box. If you later decide you want to receive the notices by mail, you must inform your employer in writing.

Empleado: *Complete la sección* ***"Empleado"*** *y entregue la forma a su empleador. Quédese con la copia designada* ***"Recibo Temporal del Empleado"*** *hasta que Ud. reciba la copia firmada y fechada de su empleador. Ud. puede llamar a la Division de Compensación al Trabajador al* ***(800) 736-7401*** *para oir información gravada. Una explicación de los beneficios de compensación de trabajadores está incluido en la Notificación de Posible Elegibilidad, que es la hoja de portada de esta forma. Separe y guarde esta notificación como referencia para el futuro.*

Ud. también debería haber recibido de su empleador un folleto describiendo los benficios de compensación al trabajador lesionado y los procedimientos para obtenerlos. Es posible que reciba notificaciones escritas de su empleador o de su administrador de reclamos sobre su reclamo. Si su administrador de reclamos ofrece enviarle notificaciones electrónicamente, y usted acepta recibir estas notificaciones solo por correo electrónico, por favor proporcione su dirección de correo electrónico abajo y marque la caja apropiada. Si usted decide después que quiere recibir las notificaciones por correo, usted debe de informar a su empleador por escrito.

Any person who makes or causes to be made any knowingly false or fraudulent material statement or material representation for the purpose of obtaining or denying workers' compensation benefits or payments is guilty of a felony.

Toda aquella persona que a propósito haga o cause que se produzca cualquier declaración o representación material falsa o fraudulenta con el fin de obtener o negar beneficios o pagos de compensación a trabajadores lesionados es culpable de un crimen mayor "felonia".

Employee—complete this section and see note above ***Empleado—complete esta sección y note la notación arriba.***

1. Name. *Nombre.* _____ Today's Date. *Fecha de Hoy.* _____
2. Home Address. *Dirección Residencial.* _____
3. City. *Ciudad.* _____ State. *Estado.* _____ Zip. *Código Postal.* _____
4. Date of Injury. *Fecha de la lesión (accidente).* _____ Time of Injury. *Hora en que ocurrió.* _____ a.m. _____ p.m.
5. Address and description of where injury happened. *Dirección/lugar dónde occurió el accidente.* _____
6. Describe injury and part of body affected. *Describa la lesión y parte del cuerpo afectada.* _____
7. Social Security Number. *Número de Seguro Social del Empleado.* _____
8. ❑ Check if you agree to receive notices about your claim by email only. ❑ *Marque si usted acepta recibir notificaciones sobre su reclamo solo por correo electrónico.* Employee's e-mail. _____ *Correo electrónico del empleado.* _____.

You will receive benefit notices by regular mail if you do not choose, or your claims administrator does not offer, an electronic service option. *Usted recibirá notificaciones de beneficios por correo ordinario si usted no escoge, o su administrador de reclamos no le ofrece, una opción de servicio electrónico.*

9. Signature of employee. *Firma del empleado.* _____

Employer—complete this section and see note below. ***Empleador—complete esta sección y note la notación abajo.***

10. Name of employer. *Nombre del empleador.* **UCLA Campus,Insurance & Risk Management**
11. Address. *Dirección.* **10920 Wilshire Blvd., Suite 860, LA, CA 90024**
12. Date employer first knew of injury. *Fecha en que el empleador supo por primera vez de la lesión o accidente.* _____
13. Date claim form was provided to employee. *Fecha en que se le entregó al empleado la petición.* _____
14. Date employer received claim form. *Fecha en que el empleado devolvió la petición al empleador.* _____
15. Name and address of insurance carrier or adjusting agency. *Nombre y dirección de la compañía de seguros o agencia adminstradora de seguros.* _____
Sedgwick,CMS P.O. Box 14533 Lexington, KY 40512-4533
16. Insurance Policy Number. *El número de la póliza de Seguro.* **self-insured**
17. Signature of employer representative. *Firma del representante del empleador.* _____
18. Title. *Título.* _____ 19. Telephone. *Teléfono.* _____

Employer: You are required to date this form and provide copies to your insurer or claims administrator and to the employee, dependent or representative who filed the claim within **one working day** of receipt of the form from the employee.

SIGNING THIS FORM IS NOT AN ADMISSION OF LIABILITY

Empleador: *Se requiere que Ud. feche esta forma y que provéa copias a su compañía de seguros, administrador de reclamos, o dependiente/representante de reclamos y al empleado que hayan presentado esta petición dentro del plazo de* ***un día hábil*** *desde el momento de haber sido recibida la forma del empleado.*

EL FIRMAR ESTA FORMA NO SIGNIFICA ADMISION DE RESPONSABILIDAD

❑ Employer copy/*Copia del Empleador* ❑ Employee copy/*Copia del Empleado* ❑ Claims Administrator/*Administrador de Reclamos* ❑ Temporary Receipt/*Recibo del Empleado*

STATE OF CALIFORNIA

DOCTOR'S FIRST REPORT OF OCCUPATIONAL INJURY OR ILLNESS

Within 5 days of your initial examination, for every occupational injury or illness, send two copies of this report to the employer's workers' compensation insurance carrier or the insured employer. Failure to file a timely doctor's report may result in assessment of a civil penalty. In the case of diagnosed or suspected pesticide poisoning, send a copy of the report to Division of Labor Statistics and Research, P.O. Box 420603, San Francisco, CA 94142-0603, and notify your local health officer by telephone within 24 hours.

1. INSURER NAME AND ADDRESS
SEDGWICK CMS P.O. BOX 14533, LEXINGTON, KY 40512

PLEASE DO NOT USE THIS COLUMN

2. **EMPLOYER NAME**
REGENTS OF UNIVERSITY OF CALIFORNIA

Case No.

3. Address No. and Street City Zip
405 HILLGARD AVENUE, LOS ANGELES, CA 90024

Industry

4. Nature of business (e.g., food manufacturing, building construction, retailer of women's clothes.)

County

5. **PATIENT NAME** (first name, middle initial, last name)

6. Sex ☐ Male ☐ Female

7. Date of Birth Mo. Day Yr.

Age

8. Address: No. and Street City Zip

9. Telephone number ( )

Hazard

10. Occupation (Specific job title)

11. Social Security Number - -

Disease

12. Injured at: No. and Street City County

Hospitalization

13. Date and hour of injury or onset of illness Mo. Day Yr. Hour _____ a.m. _____ p.m.

14. Date last worked Mo. Day Yr.

Occupation

15. Date and hour of first examination or treatment Mo. Day Yr. Hour _____ a.m. _____ p.m.

16. Have you (or your office) previously treated patient? ☐ Yes ☐ No

Return Date/Code

Patient please complete this portion, if able to do so. Otherwise, doctor please complete immediately, inability or failure of a patient to complete this portion shall not affect his/her rights to workers' compensation under the California Labor Code.

17. **DESCRIBE HOW THE ACCIDENT OR EXPOSURE HAPPENED.** (Give specific object, machinery or chemical. Use reverse side if more space is required.)

18. **SUBJECTIVE COMPLAINTS** (Describe fully. Use reverse side if more space is required.)

19. **OBJECTIVE FINDINGS** (Use reverse side if more space is required.)
A. Physical examination

B. X-ray and laboratory results (State if non or pending.)

20. **DIAGNOSIS** (if occupational illness specify etiologic agent and duration of exposure.) Chemical or toxic compounds involved? ☐ Yes ☐ No
ICD-9 Code ___ ___ ___ - ___ ___

21. Are your findings and diagnosis consistent with patient's account of injury or onset of illness? ☐ Yes ☐ No If "no", please explain.

22. Is there any other current condition that will impede or delay patient's recovery? ☐ Yes ☐ No If "yes", please explain.

23. **TREATMENT RENDERED** (Use reverse side if more space is required.)

24. If further treatment required, specify treatment plan/estimated duration.

25. If hospitalized as inpatient, give hospital name and location Date admitted Mo. Day Yr. Estimated stay

26. WORK STATUS -- Is patient able to perform usual work? ☐ Yes ☐ No
If "no", date when patient can return to: Regular work ____/____/____
Modified work ____/____/____ Specify restrictions _____

Doctor's Signature _____ CA License Number _____

Doctor Name and Degree (please type) Adam Saby, MD IRS Number _____

Address 10833 Le Conte Avenue., Suite 67-120, Los Angeles, CA 90095 Telephone Number (_____)_____

FORM 5021 (Rev. 4)
1992

Any person who makes or causes to be made any knowingly false or fraudulent material statement or material representation for the purpose of obtaining or denying workers' compensation benefits or payments is guilty of a felony.

RE: Employee: Claim No:

Employer: UCLA/UCLA MC

AUTHORIZATION FOR USE AND/OR DISCLOSURE OF MEDICAL INFORMATION:

So that Sedgwick may process your claim for workers' compensation benefits, please complete and return this form as soon as possible. A return envelope is enclosed.

For purposes of this document the term "Information" shall include all medical records, hospital and outpatient records, reports, charts, notes, histories, laboratory records and reports, diagnostic test reports, doctors' and nurses' notes, correspondence, radiological films, charges, and all other materials concerning, describing or relating to any and all care, treatment, and/or evaluation received by the undersigned.

AUTHORIZATION

The undersigned hereby authorizes Sedgwick, and/or its authorized representative or designee, to review, inspect, copy, and/or photograph any and all Information you have concerning, describing or relating to:

1. The evaluation and/or diagnosis of any mental or physical condition for which workers' compensation is now being claimed;
2. Any treatment or therapeutic regimen prescribed or recommended for any mental or physical condition for which workers' compensation is now being claimed;
3. Any and all functional limitations relating to my ability to perform my current job duties;
4. Any modification of my current job duties that is necessitated by the mental or physical condition for which workers' compensation is now being claimed. (Such Information shall include, without limitation, the Doctor's First Report of Injury & Illness (DFR), Verification of Treatment (VOT), work slips, etc.)
5. The medical rationale for any limitation identified in Item 3 above, including specifically and without limitation, a finding that I am unable to work as a result of the mental or physical condition for which workers' compensation is being claimed;
6. Any other physical and/or mental condition, irrespective of whether such condition first occurred before or after the onset of the condition for which workers' compensation is now being claimed, that has affected, may affect or is in any way related to, the onset, nature, scope, duration, prognosis or resolution of the physical or mental condition for which workers' compensation is now being claimed.

The released information is required for the following reason:

To provide for adequate preparation, investigation, evaluation, review, and discovery of a claim for workers' compensation benefits. Specifically, to determine the nature of causation and the nature and extent of any possible pre-existing, concurrent or aggravating medical conditions that might have medical, legal or factual implications in the injury or injuries as listed on my Employee Claim Form (the DWC Form 1).

A refusal to authorize access to some or all of the requested Information may result in a delay in processing my claim for workers' compensation benefits and/or a denial of my claim.

Release records and information regarding:

Name of Patient (List Other Names Used)	*Medical Record Number*	*Date of Birth (please verify)*
Address	*Telephone Number*	*Soc Sec # (please verify)*

Release medical information to: Sedgwick and

Name of Receiving Party

P.O. Box 14533 Lexington KY 40512-4533

Address City State Zip

DURATION: I understand that this authorization shall become effective immediately upon execution and shall remain in effect until one year from the date of my signature.

REVOCATION: I understand that this Authorization may be revoked in writing by the undersigned at any time. Written revocation will be effective upon receipt, but will not be effective to the extent that Sedgwick or any disclosing party (medical or healthcare provider) has previously acted in reliance upon this Authorization.

REDISCLOSURE: I expressly authorize Sedgwick to disclose my Information to any employee, representative, agent, or third person as may be necessary for the proper evaluation and processing of my claim. I understand that the third persons to whom my Information may be given include, without limitation, attorneys, nurse case managers, rehabilitation specialists, physicians and other experts and consultants engaged by Sedgwick to assist it in the evaluation and management of my claim. Any such disclosure to third persons will be made in confidence and in accordance with the provisions of any applicable law. I also understand that Sedgwick may disclose my Information in any manner that is required by law (e.g., subpoena, court order, etc.)

SPECIFY RECORDS: Check the box and initial which type of information is to be disclosed.

☒ **MEDICAL INFORMATION** _____ *Initial*

☐ **PSYCHIATRIC INFORMATION**

_____
Signature *Date*

☐ **DRUG/ALCOHOL INFORMATION**

_____
Signature *Date*

☐ **RESULTS OF AN HIV BLOOD TEST**

_____
Signature *Date*

☐ **OTHER HEALTH INFORMATION** (specify) _____

A photocopy of this authorization is as valid as the original.

I have read this authorization and fully understand its entire contents. I understand that by signing this form I am authorizing ALL PROVIDERS to release my Information as provided for above. I have asked questions about anything that was not clear to me and am satisfied with the answers I have received. I understand that I have a right to receive a copy of this authorization upon my request.

_____ _____
Signature of Patient or Patient's Representative *Date*

_____ _____
Indicate Relationship (if Signed by Other Than Patient) *Date*