

This report is to be completed when an occupational illness or incident occurs. If an employee is injured or develops a job-related illness (developed gradually e.g., tendonitis) as a result of their employment at UCSB they must complete and submit this report. *If the employee is unable to complete or sign the form, the supervisor or department representative must complete it on their behalf.*

CALL 1-877-682-7778 (toll free, 24 hours a day) to report the injury.

If you have any questions, please call the Workers' Compensation Office at 893-8050, or visit our website at <http://www.workcomp.ucsb.edu/>

EMPLOYEE INFORMATION – TO BE COMPLETED BY EMPLOYEE

Please complete each section. When you have completed the form and are satisfied with your answers please give this form to your supervisor.

Name:		Employee ID#:	
Local Address:		City:	State: Zip:
Home Phone:	Cell Phone:	Work Phone:	
Department:		Job Title	
Hours Worked: Days per Week:	Hours per Week:		
Do you have other employment? <input type="checkbox"/> Yes <input type="checkbox"/> No If so, where:			
INCIDENT INFORMATION			
Date of Incident:		Time of Incident:	
Date Incident Reported:		Incident Reported to:	
Address/Bldg. name & room # where incident occurred:			
Type of Injury (e.g., laceration, strain, etc.):		Part of Body:	
Describe how incident occurred:			
Please list the name(s) and phone number(s) of any witnesses:			
Is this a new injury? <input type="checkbox"/> Yes <input type="checkbox"/> No If "no", please indicate date of original injury:			
INITIAL MEDICAL TREATMENT			
Was treatment received?: <input type="checkbox"/> No medical treatment-reporting only <input type="checkbox"/> First Aid <input type="checkbox"/> Treatment was/will be provided by:			
Medical Facility:		Doctor/Provider Name:	
I, the injured employee, herein certify the information above is true and to best of my knowledge			
Signature of Employee:		Date:	

DEPARTMENT INFORMATION – TO BE COMPLETED BY SUPERVISOR OR DESIGNEE

*Please complete this form **within 24 hours** of your first notice of incident, and fax (893-8521) or forward via email to the Workers' Compensation Office.*

Supervisor Name:		Supervisor Title:	
Work Phone:		Email Address:	
INCIDENT INFORMATION			
Did employee lose time from work? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown If 'yes': First day of lost time:			
Description of injury:			
Was there equipment involved? <input type="checkbox"/> Yes <input type="checkbox"/> No If "yes" what was the equipment:			
Were other employees injured: <input type="checkbox"/> Yes <input type="checkbox"/> No		Name(s):	
What action will be taken to prevent recurrence?			
Other Comments:			
Signature of Department Designee:		Date:	

Incident Reporting ensures there is a record on file with the employer. In no way does this waive the employee's right to workers' compensation benefits. If an injury occurs, first aid may be appropriate treatment. "First aid" means any one-time treatment and any follow-up visit(s) for the purpose of observation of minor scratches, cuts, burns, splinters, or other minor industrial incident, which do not ordinarily require medical care. This one-time treatment and follow-up visit for the purpose of observation is considered first aid even though provided by a physician or registered professional personnel. Filing of a first aid incident report is not a filing of a workers' compensation claim. An employee retains their right to file a workers' compensation claim at a later date. If, initially, first aid is rendered but at a later date treatment beyond first aid is required, please contact the Workers' Compensation Department immediately and initiate the filing of a workers' compensation claim.