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.

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)

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?	

INCIDENT

DATE OF INCIDENT: _____ / _____ / _____ AT _____:_____ ☐ AM ☐ PM	TIME WORK BEGAN: _____:_____	TIME WORK STOPPED: _____:_____

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:	

TREATMENT

DID YOU RECEIVE MEDICAL TREATMENT?
☐ YES ☐ NO (SKIP THIS SECTION)

IF YES, LIST MEDICAL PROVIDER NAME AND ADDRESS

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)

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?

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):
2. **Environment** *and Work Area*	☐ Uneven surface ☐ Slippery surface ☐ Insufficient lighting	☐ Noisy environment ☐ Poor housekeeping ☐ Improper work area setup	☐ Other (please describe):
3. **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):
4. **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).

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.			

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:

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