UCDMC WC DEPARTMENTAL INJURY/ILLNESS WORKSHEET

1. PLEASE TYPE OF PRINT NEATLY. MAIL OR FAX **WITHIN ONE WORKING DAY** OF KNOWLEDGE TO WORKERS' COMPENSATION – FAX 734-2484
2. STATE LAW REQUIRES THAT AN EMPLOYEE'S CLAIM FOR WORKERS' COMPENSATION BENEFITS DWC FORM 1 BE PROVIDED **WITHIN ONE DAY**.
3. **SERIOUS INJURIES (INCLUDING HOSPITALIZATION, LOSS OF LIMB, OR LIFE) MUST BE REPORTED TO THE ENVIRONMENTAL HEALTH & SAFETY (EH&S) HEALTH AND SAFETY OFFICER *IMMEDIATELY* AT 916-734-2740, AFTER HOURS CALL THE EH&S 24 HOUR PAGER AT 916-816-1994**. THE EH&S OFFICE MUST REPORT THE INCIDENT TO CAL/OSHA WITHIN 8 HOURS OF KNOWLEDGE OF A SERIOUS INJURY TO EMPLOYEE.

Failure to comply may result in penalties being assessed to the department. Please call Workers' Compensation at 734-6180 if assistance is needed.

DATA

Name (last, first): | Home Phone:

Address (street): | City/State/Zip:

Soc. Sec No.: | Sex: ☐ female ☐ male ☐ other

Department Name: Cost Center #: | Work Phone:

Supervisor's Name: | Supervisor's Phone:

Job Title: | Appointment: % | UC Date of Hire (m-d-y):

Employee Usually Works: hours per day days per week = total weekly hours

Status (Check all that apply): ☐ full-time ☐ part-time ☐ per diem ☐ casual/temporary ☐ student ☐ volunteer ☐ WOS

Date of Injury/Illness (m-d-y): | Injury time: ☐ am ☐ pm | Time Began Work: ☐ am ☐ pm

Unable to Work for at Least One Full Day After Injury Date? ☐ Yes ☐ No | Date Last Worked (m-d-y):

Is Employee Still Off Work? ☐ Yes ☐ No | Date Returned to Work (m-d-y):

For TSS Employees, Dept. & Cost Center # of Assignment: | County:

EMPLOYEE

Location Where Event Occurred (i.e., Hospital 3rd floor parking lot 12): | UCDMC Premise ☐ Yes ☐ No

Specific Injury/Illness & Body Part Affected (i.e., Fracture of Right Hand): | Others Injured? ☐ Yes ☐ No

Explain in Detail How Event Occurred:

Specific Activity You Were Performing (i.e., loading boxes, typing):

If Lifting, did you have assistance? ☐ Yes ☐ No If yes, how many others helped you lift?

Equipment or Chemicals Being Used: (If lifting, approximate weight of object)

Please list any witnesses:

☐ No Medical Action.. Seen at Employee Health Services ☐ Yes ☐ No Names/Addresses/Phones of other Physicians/Hospitals who treated you for this Injury/Illness:

Other Employment (in addition to UCDMC): ☐ Yes ☐ No If yes, name of other employer:

Reported on Workers' Compensation Claim Line Date: **If no, Call the Claim Line Immediately at Ext. 4-8789**

Employee Signature: | Today's Date (m-d-y):

SUPERVISOR

EMPLOYEE'S CLAIM DWC FORM 1 PROVIDED ON (m-d-y): | Department Notified of Injury/Illness on (m-d-y):

Paid Full wages for Day of Injury or Last Day Worked? ☐ Yes ☐ No | If Employee Died Date of Death (m-d-y):

Comment on the Circumstances of the Injury:

Were safe work practices followed? ☐ Yes ☐ No (Occupational Safety is a Resource call 734-2740)

What Steps have You Taken, or will Take, to Prevent Similar Injuries/Illness?

If you Feel the Employee's Condition is Not Related to His/her Employment, Please Explain providing Any Evidence You Have to Support This:

Supervisor's Signature | Today's Date (m-d-y):

Department Head's Signature (if available) | Today's Date (m-d-y):