Safety Note # 123

REPORTING AN EMPLOYEE INJURY OR ILLNESS

Each year, work-related injuries cost the University millions of dollars and thousands of hours of lost time. Promptly reporting an injury or illness can ensure that proper first aid or professional medical care is provided and steps are taken to prevent accident or sickness recurrence. This Safety Note provides guidance for ANR employees on the reporting of injuries or illnesses that occur during the course of work. It is important that employees report all work-related injuries or illnesses to their supervisor immediately. In addition, you are encouraged to report "close calls" or "near-miss" incidents where an injury could have occurred, but was avoided. Incidents involving injury to a non-employee or property damage/loss are to be reported on a UC ANR Incident Report form – see Safety Note #163.

Employee Responsibilities - When injured at work, please follow these steps:

- Report the injury to your supervisor immediately.
- As needed, obtain first aid or professional medical care promptly.
- If you are unable to work because of the injury, you must provide your supervisor with medical certification of any and all disability leave dates and any changes in disability leave dates.

Obtaining Prompt Medical Care

If Emergency Treatment is Required:	For Non-Emergency Care:
Go to the nearest emergency room. Report the injury to your supervisor as soon as possible. For follow-up care, go to your location's designated occupational health clinic.	Immediately report the injury to your supervisor. If care beyond first aid is needed, medical care should be obtained at your location's designated occupational health clinic, unless you have chosen to designate your personal physician prior to the injury (see Physician Designation form).

If your location has not designated an occupational health clinic, then use a local clinic that accepts Worker's Compensation.

Supervisor Responsibilities

- Ensure that the injured employee gets first aid or professional medical care as needed.
- Contact the appropriate administrative office to report the injury as described below.
  - UC ANR Employees at all locations other than Oakland
    Within 24 hours, report the injury using one of the following methods:
    a. **Online Report (preferred)**: Injuries may be reported using the Online Employer First Report form. The employee or another staff member may initiate the report at: http://ehs.ucop.edu/efr. Note: a UC Davis kerberos login is required to access the form. Once the report is submitted, the supervisor will be prompted to complete additional information. Notification of the report will also go to Staff Personnel Unit.
    b. **Paper form**: Injuries may be reported to the Staff Personnel Unit (including Academic personnel). Use the UC Davis Employers Report of Occupational Injury or Illness form to report injuries and e-mail to**:** mailto:anrstaffpersonnel@ucanr.edu or fax to: (530) 756-1180. For additional help with the form, consult the Employers Report Instructions or Employers Report Example.
    c. After normal business hours, if the treating clinic needs insurance or claims information, call 1-877-682-7778 to report the injury and get the claims process started.
  - UC ANR Employees based at UCOP in Oakland – Injuries are reported to UCOP Human Resources. For detailed instructions see: http://www.ucop.edu/local-human-resources/op-life/leaves-of-absence/when-injury-occurs-employee.html
- The supervisor must complete the Employer's Investigation portion of the form and sign (or submit electronically).
- The Workers' Compensation office (at UC Davis or UCOP) will determine if a Workers' Compensation claim is appropriate and will provide an Employee's Claim Form (DWC 1 Rev. 1/94). Have the employee complete the Claim Form and return to Workers Compensation.
- Submit all required forms to the Staff Personnel Unit, UC Davis Workers' Compensation office (or UCOP Workers' Compensation office), and maintain a copy for the employee file.

To report *SERIOUS* work-related injuries or illnesses -such as fatality, amputation, or injury/illness that requires hospitalization– see Safety Note #76.

To report incidents other than employee work-related injuries - such as theft, property damage or injuries to non-employees- see Safety Note #163.

UNIVERSITY OF CALIFORNIA Risk & Safety Solutions

Employer's First Report of Injury (EFR)

Employer's First Report is a web based application which allows claims administrators and supervisors to track initial causes of injuries and verify corrective actions have been taken to reduce the likelihood of repeated injuries.

1 Claimant

- Submits injury claim
- Submission generates email notification to Supervisor and Claim Administrator

2 Supervisor

- Acknowledges injury claims
- Performs employer investigation
- Tracks and verifies corrective actions

3 Administrator

- Reviews and processes claim submission
- Monitors and tracks work status

Features

- User-friendly interface
- Mobile friendly
- Claim validation
- Automated claim submission to iVos

Benefits

- Captures information to reduce risks
- Tracks preventative actions
- Tracks and monitors work status
- Complies with OSHA regulations

To learn more about the Employer's First Report application, please contact the ERM Service Desk at **erm@ucop.edu or (530) 638-DESK (3375)**

USE THIS FORM IF ONLINE EFR REPORT IS NOT AVAILABLE

UCD Employer's Report of Occupational Injury or Illness

UNIVERSITY POLICY REQUIRES THAT INDUSTRIAL INJURY/ILLNESS BE REPORTED TO WORKERS' COMPENSATION WITHIN 24 HOURS OF OCCURRENCE AND STATE REGULATIONS REQUIRE THAT ALL ACCIDENTS BE INVESTIGATED.
In the event of a serious injury or hospitalization, call Workers' Compensation immediately at (530) 752-7243. This form must be completed in its entirety and mailed or faxed (530) 752-3439 to Workers' Compensation. Omission of information could result in a delay of benefits.

EMPLOYEE MUST COMPLETE THESE SECTIONS:

EMPLOYEE DATA

Employee Name:		Employee's UCDavis ID #:
Address:		Home Phone: ( )
City/State/Zip:	Sex: ☐Female ☐Male	Date of Birth:
Department/Location:		Employee's Work Phone: ( )
Payroll Title/TC:	Date of Hire:	Annual Gross Salary: $
Supervisor's Name:		Supervisor's Work Phone: ( )
Employee ( ) Volunteer ( ) Student-Employee ( )	( )hours per day	( ) days per week ( ) total weekly hours

EMPLOYEE STATEMENT

Specific Injury/Illness/Exposure:	Body Part(s) affected:	Date of injury/illness:
Location where injury or illness occurred:		Others Injured? ☐Yes ☐No
What equipment, materials or chemicals caused the injury/illness? :		Who witnessed this injury?

Explain in detail how the injury occurred. Include specific activities/tasks performed at the time.

Medical Treatment provided by:
___Employee Health Services ___Sutter Davis Hospital ER Other: (Provide Name &Phone #) _____
___Private Physician ___UC Davis Medical Center _____
___First Aid, no medical care needed.

Employee Signature: Today's Date:

EMPLOYER'S INVESTIGATION AND STATEMENT (EMPLOYER COMPLETES):

EMPLOYER

After the investigation, explain in detail how the injury/illness occurred and the specific activity being performed:

What was the injury, illness or exposure?

INITIAL CAUSE

- ☐ Struck by or against object (indicate) _____
- ☐ Caught in/under/ between
- ☐ Fall / Slip / Trip
- ☐ Material handling or lifting
- ☐ Repetitive motion
- ☐ Chemical exposure
- ☐ Body fluid exposure:
  - __Needle stick
  - __Sharps
- ☐ Animal bite
- ☐ Other, Explain _____

CONTRIBUTING FACTORS AND ACTIVITIES

Equipment
- ☐ Equipment failure
- ☐ Equipment unavailable
- ☐ Improper equipment or material used for job

Personal protective equipment
- ☐ Not worn
- ☐ Not readily available
- ☐ Not adequate for the task
- ☐ Personal protective equipment failure

Training/Experience
- ☐ Lack of training
- ☐ Safety training provided, not followed
- ☐ New task for employee or lack of experience

Work Area
- ☐ Work area set up improperly
- ☐ Inadequate lighting or noise issues
- ☐ Housekeeping issues
- ☐ Environmental factors (rain, wind, temp. etc)
- ☐ Ventilation issues
- ☐ Ergonomic factors

Employee
- ☐ Physically not able to do work
- ☐ Employee fatigue
- ☐ Unbalanced or poor position or motion
- ☐ Incorrect procedures used for task
- ☐ Other unsafe practice

Assistance
- ☐ Difficult to perform task without help
- ☐ Safety features or devices not readily available
- ☐ Assistive devices not used

- ☐ **Lack of policy/procedure**
- ☐ **Animal** (explain below)
- ☐ **Other** (explain) _____

Use additional pages as needed

PREVENTIVE ACTIONS

SUPERVISOR WILL:
- ☐ Develop/revise safety procedures and update IIPP or Chem. Hyg. Plan
- ☐ Request ergonomic evaluation
- ☐ Order new equipment
- ☐ Order new personal protective equipment
- ☐ Remove equipment from use and repair/replace
- ☐ Schedule preventive maintenance
- ☐ Will retrain employee before task is re-assigned.
- ☐ Perform on-site review of work activity, update job safety analysis.
- ☐ Reconfigure work area
- ☐ Communicate corrective actions to others in job category.
- ☐ Other_____

Preventive actions will be completed by:
Name_____

Expected date of completion_____

SUPERVISOR'S OR MANAGER'S SIGNATURE:	**Date of Investigation:**
DEPARTMENT HEAD'S SIGNATURE:	**Date:**

PLEASE NOTE: COMPLETING THIS FORM IS NOT AN ADMISSION OF UNIVERSITY LIABILITY