SUPERVISOR REPORT OF EMPLOYEE INJURY

(For reporting work-incurred injuries and illnesses only)

UCSF

University of California San Francisco

... A Health Sciences Campus

INJURIES AND ILLNESSES MUST BE REPORTED WITHIN 24 HOURS

IMPORTANT INSTRUCTIONS FOR SUPERVISORS: WITHIN 24 HOURS:

CAMPUS SUPERVISORS: Complete this form and FAX it to Disability Management Services, (415) 476-2328, then mail it to DMS at UCSF Box 0964.

MED CTR SUPERVISORS: Complete this form and FAX it to Employee Health Services, (415) 771-4472, then mail it to EHS at UCSF Box 1661.

SUPERVISORS: DISTRIBUTE COPIES OF THIS FORM TO ADMINISTRATIVE AND SAFETY UNITS LISTED AT THE BOTTOM OF THE FORM.

If injury is SERIOUS OR FATAL: Immediately report the injury by phone: CAMPUS (DMS): (415) 476-2621. MEDICAL CENTER (EHS): (415) 885-7580.

LATE SUBMISSION OF THIS FORM. OR FAILURE TO COMPLETE IT IN ITS ENTIRETY. MAY DELAY PROVISION OF BENEFITS, AND RESULT IN FINES AND PENALTIES BEING ASSESSED AGAINST YOUR DEPARTMENT. PLEASE PRINT:

DEPARTMENTIUNIT NAME:

DEPARTMENT ROOT (CHECK ONE ONLY): _CAMPUS _ MEDICAL CENTER

SUPERVISOR NAME: | BOX:

PHONE: | FAX:

EMAIL:

PAYROLL PROCESSOR NAME:

EMPLOYEE NAME (Last, First, MI):

WORK PHONE: | HOME PHONE:

SOCIAL SECURITY NUMBER SSN):

HOME STREET ADDRESS:

CITY, STATE

ZIP CODE:

DATE OF BIRTH:

DATE OF HIRE:

JOB TITLE (EX: AAI, SR. CUSTODIAN):

GENDER: M F

DATE OF INJURY:

TIME OF INJURY:

TIME BEGAN WORK:

TIME STOPPED WORK:

DATE EMPLOYEE REPORTED INJURY:

LOCATION OF INJURY (STREET, BLDG., ROOM):

WITNESSES TO INJURY, IF ANY:

WHAT WAS THE EMPLOYEE DOING WHEN THE INJURY HAPPENED? (EXAMPLE: Lifting boxes of books.)

WHAT HAPPENED? (EXAMPLE: Employee dropped box of books on right foot.)

WHAT WAS THE INJURY OR ILLNESS? (EXAMPLE: Fractured right foot.)

WHAT OBJECT OR SUBSTANCE DIRECTLY HARMED THE EMPLOYEE? (EXAMPLE: Box of books.)

MEDICAL TREATMENT REFERRAL:
_Employee Health Services _Urgent Care
Long Emergency Other:

TYPE OF EVENT	CONTRIBUTING CONDITIONS	CONTRIBUTING BEHAVIORS	PREVENTIVE ACTIONS
_Struck by (what)	_Lack of Policy/Procedure	Unbalanced or Poor Position or Motion	SUPERVISOR WILL:
_Caught in / under / between	_Lack of Training	_Rushing or Hurried	_Schedule Safety Training
_Fll / Slip / Trip	_Equipment Failure	_Failure to Get Assistance	_Develop/Revise Safety Procedures
_Material Handling or Lifting	_Equipment Unavailable	_Inattention to Task	_Order/Post Warning Signs
_Patient Handling or Lifting	_Work Area Set-up/Arrangement	_Safety Procedure Not Followed	_Order Protective Equipment
_Repetitive Motion	_Ergonomic Factors	_Assistive Device Not Used	_Remove Equipment from Use
_Chemical Exposure	_Ventilation	_Protective Equipment Not Worn	_Report Equipment/Condition to:
_Body Fluid Exposure	_Lighting	_Safety Features of Devices Bypassed	
_Needlestick or Sharps	_Vibration		
Other:	Other:	Other:	Other:

APPOINTMENT: _CAREER _LIMITED _PER DIEM _FLOAT

EARNINGS (include Shift Differential):

Employee earns: $ per: YEAR MONTH BI-WEEKLY HOUR

FULL TIME PART TIME % TIME: %

Employee works: hours per week

SUPERVISOR CHECKLIST

EMPLOYEE REFERRED FOR MEDICAL CARE? -Yes _No
IF YES, REFERRED TO EMPLOYEE HEALTH? -Yes _No
LOST WORK DAYS BEYOND DATE OF INJURY? -Yes -No
IF LOST WORK DAYS BEYOND THE DATE-OF INJURY

DATE LAST WORKED:
DATE RETURNED TO WORK: STILL OFF
WC PAYROLL PROCEDURES INITIATED? _Yes _No
FMLA PACKET SENT TO EMPLOYEE? _Yes _No

TRANSITIONAL/MODIFIED WORK

Providing appropriately Modified Work during the transitional stages of your employee's medical recovery can retain productivity, and significantly reduce the cost of disability to your employee, your department, and the University as a whole.

WE HAVE PROVIDED TRANSITIONAL MODIFIED WORK: _Yes _No
WE WILL PROVIDE TRANSITIONAL MODIFIED WORK: _Yes _No
WE WOULD LIKE ASSISTANCE IN DESIGNING TM WORK: Yes No

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

SUPERVISOR OR MANAGER SIGNATURE: | DATE: