Manager's Report of Incident Form

Manager (or other department representative) must complete this form for all work-related incidents whether an employee seeks medical care or not. Answer each question fully. Failure to submit this information in a timely manner will delay benefits.

HR Partner should then submit this form, with completed Workers' Compensation Claim Form (DWC-1), to USC Disability Management via fax ***(213) 740-7305***. Keep a copy for home department records.

Employee information

Name (first and last)

Employee ID number (either 7 or 10 digits)

Female

Date of birth (mm/dd/yyyy) **Gender**

Phone number

CA

Address **City** **State** **Zip**

Occupation (regular job title, no initials, abbreviations or numbers)

Date of hire (mm/dd/yyyy)

Employee usually works **hours per day,** **days per week,** **total weekly hours**

Employment status:

☐ **regular, full time** ☐ **part-time** ☐ **temporary** ☐ **seasonal**

Gross wages/salary **per** bi-weekly

Other payments not reported as wages/salary (for example, tips, meals, overtime, bonuses, etc.)**?** ☐ **Yes** ☐ **No**

List any concurrent employment

Incident information

Location of incident (building and room)

Address

pm pm

Date of incident (mm/dd/yyyy) **Time of incident (hh:mm)** **Time employee began work (hh:mm)**

pm

Date incident was reported to manager (mm/dd/yyyy) **Time of report (hh:mm)**

Describe what employee was doing just before the incident occurred. Include the activity and any tools, equipment and material used (for example, "using knife to cut lettuce for salad")

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Incident information (continued)

Describe how accident occurred. Indicate injured body part or illness involved (for example, "knife slipped and cut left index finger")

Indicate name and contact information of any 3rd party responsible for the incident, if applicable (person or company)

List names and contact information of any witnesses

Was work time lost as a result of this incident? ☐ Yes ☐ No

Has employee returned to work? ☐ Yes ☐ No **If yes, when?** (mm/dd/yyyy)

Is modified work available? ☐ Yes ☐ No **If yes, for how long?** _____

For needle sticks only

Brand **Model**

Was the sharps protection activated? ☐ Yes ☐ No

If yes, when? ☐ before injury ☐ during injury ☐ after injury

If no, explain

Treatment information

Treatment provided by

☐ Engemann Student Health Center ☐ Internal Medicine (HCC II)

☐ emergency room ☐ hospitalization ☐ other

List name and address of physician who administered treatment, if applicable

Declination of medical treatment

☐ Employee declined medical treatment. Ensure employee signs the declination of workers' compensation form.

Manager signature

Manager's signature **Date** (mm/dd/yyyy)

Manager's employee ID number **Phone extension**