

SUPERVISOR INCIDENT REPORT (FOR REPORTING NEAR MISSES AND WORK-RELATED INJURIES & ILLNESSES) INCIDENTS MUST BE REPORTED TO HR DMS WITHIN 24 HOURS PREVENTIVE CONTROLS SHOULD BE IMPLEMENTED IMMEDIATELY	UCSF University of California San Francisco ... A Health Sciences Campus
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TYPE OF INCIDENT (check one): <input type="checkbox"/> NEAR MISS <input type="checkbox"/> INJURY/ILLNESS	If injury occurs and is SERIOUS OR FATAL : <u>Immediately</u> report the injury <u>by phone</u> to: EH&S (415) 476-1300 & DMS (415) 476-2621. <i>LATE REPORTING MAY DELAY PROVISION OF BENEFITS OR MANDATORY NOTICES, RESULTING IN STATE FINES OR PENALTIES BEING ASSESSED AGAINST YOUR DEPARTMENT.</i>
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DEPARTMENT/UNIT NAME: _____	DEPARTMENT ROOT (check one): <input type="checkbox"/> CAMPUS <input type="checkbox"/> LPPI <input type="checkbox"/> MED CTR
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SUPERVISOR NAME: _____	BOX: _____	WORK PHONE: _____	FAX: _____	EMAIL: _____
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EMPLOYEE NAME (Last, First, MI): _____	WORK PHONE: _____	OCCUPATION/JOB TITLE: _____
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DATE OF INCIDENT: _____	TIME OF INCIDENT: _____	TIME BEGAN WORK: _____	TIME STOPPED WORK: _____	DATE EMPLOYEE REPORTED INCIDENT: _____
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LOCATION OF INCIDENT (STREET, BLDG., ROOM): _____	WITNESSES TO INCIDENT, IF ANY: _____
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WHAT WAS THE EMPLOYEE DOING JUST BEFORE THE INCIDENT OCCURRED? DESCRIBE ACTIVITY, TOOLS, EQUIPMENT, MATERIALS, ETC.

WHAT HAPPENED? TELL US IN DETAIL HOW THE INCIDENT OCCURRED:

WAS THERE EQUIPMENT INVOLVED? <input type="checkbox"/> YES <input type="checkbox"/> NO IF "YES" WHAT WAS THE EQUIPMENT? _____	DID EQUIPMENT MALFUNCTION CAUSE THE INCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO If "YES": Remove the equipment from use, tag it for identification, store it securely, and notify both EH&S (415) 476-1300 & DMS (415) 476-2621.
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1. TYPE OF EVENT	2. CONTRIBUTING CONDITIONS	3. CONTRIBUTING BEHAVIORS	4. PREVENTIVE ACTIONS
<input type="checkbox"/> Body Motion / Body Position <input type="checkbox"/> Caught in / under/ between <input type="checkbox"/> Contact by / Contact with <input type="checkbox"/> Explosion <input type="checkbox"/> Exposure <input type="checkbox"/> Over-exposure <input type="checkbox"/> Over-exertion <input type="checkbox"/> Slip / Trip / Fall <input type="checkbox"/> Struck by / Struck against <input type="checkbox"/> Vehicular Accident <input type="checkbox"/> Other: _____	<input type="checkbox"/> Duties or Tasks not clear <input type="checkbox"/> Equipment or Tool Defect/Failure <input type="checkbox"/> Equipment or Tool Unavailable <input type="checkbox"/> Ergonomic Factors <input type="checkbox"/> Lighting/ Temperature / Ventilation <input type="checkbox"/> Procedure Lacking or Unclear <input type="checkbox"/> Training Lacking or Incomplete <input type="checkbox"/> Work Area Set-up/Arrangement <input type="checkbox"/> Work Area Clutter <input type="checkbox"/> Unrecognized Hazard: _____ <input type="checkbox"/> Other: _____	<input type="checkbox"/> Assistive Device Not Used <input type="checkbox"/> Failure to Get Assistance <input type="checkbox"/> Improper Tool/Equipment Used <input type="checkbox"/> Inattention to Task <input type="checkbox"/> Lack of Communication <input type="checkbox"/> Procedure Not Followed <input type="checkbox"/> Protective Equipment Not Worn <input type="checkbox"/> Rushing or Hurried <input type="checkbox"/> Safety Features of Devices Bypassed <input type="checkbox"/> Unbalanced or Poor Position or Motion <input type="checkbox"/> Other: _____	SUPERVISOR WILL: <input type="checkbox"/> Develop/Revise Safety Procedures <input type="checkbox"/> Maintain Good Housekeeping <input type="checkbox"/> Maintain Tools/Equipment <input type="checkbox"/> Post Safety Signs <input type="checkbox"/> Perform Job Hazard Analysis <input type="checkbox"/> Perform Task Safety Analysis <input type="checkbox"/> Provide Protective Equipment <input type="checkbox"/> Remove Equipment from Use <input type="checkbox"/> Schedule Safety Training <input type="checkbox"/> Other: See next line, below.

LIST ANY OTHER ACTIONS THAT WILL BE TAKEN OR CONTROL MEASURES THAT WILL BE PUT IN PLACE TO PREVENT RECURRENCE:

PROBABILITY: ESTIMATE THE PROBABILITY OF A RECURRENCE. 1. WITHOUT PREVENTIVE MEASURES: <input type="checkbox"/> LOW <input type="checkbox"/> MEDIUM <input type="checkbox"/> HIGH 2. WITH PREVENTIVE MEASURES: <input type="checkbox"/> LOW <input type="checkbox"/> MEDIUM <input type="checkbox"/> HIGH	SEVERITY: ESTIMATE THE SEVERITY OF SUCH A RECURRENCE. 1. WITHOUT PREVENTIVE MEASURES: <input type="checkbox"/> LOW <input type="checkbox"/> MEDIUM <input type="checkbox"/> HIGH 2. WITH PREVENTIVE MEASURES: <input type="checkbox"/> LOW <input type="checkbox"/> MEDIUM <input type="checkbox"/> HIGH
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DID INJURY OR ILLNESS OCCUR? <input type="checkbox"/> YES <input type="checkbox"/> NO	IF INJURY OR ILLNESS OCCURRED, TELL US WHAT PARTS OF THE BODY WERE AFFECTED AND HOW: _____
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IF INJURY OR ILLNESS OCCURRED, WHAT OBJECT OR SUBSTANCE DIRECTLY HARMED THE EMPLOYEE?

WHERE WAS THE EMPLOYEE REFERRED FOR MEDICAL CARE? Employee Health Services Urgent Care Long Emergency

Other: _____

SUPERVISOR CHECKLIST	TRANSITIONAL/MODIFIED WORK
EMPLOYEE REFERRED FOR MEDICAL CARE? <input type="checkbox"/> YES <input type="checkbox"/> NO IF YES, REFERRED TO EMPLOYEE HEALTH? <input type="checkbox"/> YES <input type="checkbox"/> NO EE LOST TIME FROM WORK ON DATE INJURED? <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> UNK EE WILL BE PAID IN FULL FOR DATE INJURED? <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> UNK EE LOST TIME AFTER DATE INJURED? <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> UNK IF EMPLOYEE LOST TIME AFTER DATE INJURED DATE EMPLOYEE WAS LAST AT WORK : _____ DATE EMPLOYEE RETURNED TO WORK: _____ <input type="checkbox"/> STILL OFF W/C PAYROLL PROCEDURES INITIATED? <input type="checkbox"/> YES <input type="checkbox"/> NO FMLA PACKET SENT TO EMPLOYEE? <input type="checkbox"/> YES <input type="checkbox"/> NO	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 <u>HAVE PROVIDED</u> TRANSITIONAL MODIFIED WORK: <input type="checkbox"/> YES <input type="checkbox"/> NO WE <u>WILL PROVIDE</u> TRANSITIONAL MODIFIED WORK: <input type="checkbox"/> YES <input type="checkbox"/> NO WE <u>REQUEST ASSISTANCE</u> IN DESIGNING TM WORK: <input type="checkbox"/> YES <input type="checkbox"/> NO

SUPERVISOR COMMENTS (SAFETY AND INJURY/ILLNESS PREVENTION) - attach separate sheet if desired:

PLEASE NOTE: COMPLETING THIS FORM IS <u>NOT</u> AN ADMISSION OF UNIVERSITY LIABILITY	SUPERVISOR OR MANAGER SIGNATURE: _____	DATE: _____
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