



# INCIDENT REPORT

Injury/Illness

First Aid

Near Miss

*Complete All Sections Thoroughly and Forward to Risk & Safety Department*

## I. EMPLOYEE DATA

Employee Name:		Job Title:		Department:	
Date of Birth:	Home Address:			Home Phone Number:	
Date of Incident:	Time of Incident: _____ <input type="checkbox"/> a.m. <input type="checkbox"/> p.m.		Date of Report:	Time Employee Began Work: _____ <input type="checkbox"/> a.m. <input type="checkbox"/> p.m.	
Supervisor:		Location of Incident:		Date employee reported:	

## II. INCIDENT DATA

What specific activity employee was performing before and when the incident occurred:

How did the incident occur, describe the sequence of events (answer who, what , when where and why)

What object/action caused harm to the employee: \_\_\_\_\_ Were tools/equipment contaminated with bodily fluids?  
 Yes  No

List tools, equipment and PPE used at the time of the incident:

Were other workers injured?  Yes  No Pictures included?  Yes  No

### OBSERVATION OF INCIDENT

<input type="checkbox"/> Allergic Reaction	<input type="checkbox"/> Amputation	<input type="checkbox"/> Burn	<input type="checkbox"/> Chemical Exposure
<input type="checkbox"/> Head Injury	<input type="checkbox"/> Heat Related Illness	<input type="checkbox"/> Laceration/Cut	<input type="checkbox"/> Strain/Sprain
<input type="checkbox"/> Other (please list):			

Specific body part(s) injured:

### MEDICAL CARE

<input type="checkbox"/> First-Aid	<input type="checkbox"/> Workers Comp Clinic	<input type="checkbox"/> Emergency Room
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### WITNESSES

Any witnesses: <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, list witness(s) & include witness statement(s):
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*Include photos, witness statement and any other relevant information*



### III. CAUSE: Check at least 1 from each column that may have contributed to the incident

Unsafe Acts	Unsafe Conditions	Management System Deficiencies
<input type="checkbox"/> Improper PPE, not used/used incorrectly	<input type="checkbox"/> Poor workstation design/layout	<input type="checkbox"/> Lack of written procedures/safety rules
<input type="checkbox"/> Safety rule/procedure violation	<input type="checkbox"/> Fire or explosion hazard	<input type="checkbox"/> Safety rules not enforced
<input type="checkbox"/> Improper work technique	<input type="checkbox"/> Congested work area	<input type="checkbox"/> Hazards not identified
<input type="checkbox"/> Operating without authorization	<input type="checkbox"/> Hazardous substances	<input type="checkbox"/> PPE unavailable
<input type="checkbox"/> Failure to warn or secure	<input type="checkbox"/> Inadequate ventilation	<input type="checkbox"/> Insufficient worker training
<input type="checkbox"/> Operating at improper speeds	<input type="checkbox"/> Improper material storage	<input type="checkbox"/> Insufficient supervisor training
<input type="checkbox"/> By-passing safety devices	<input type="checkbox"/> Improper tool/equipment for task	<input type="checkbox"/> Improper maintenance
<input type="checkbox"/> Guards not used	<input type="checkbox"/> Insufficient knowledge	<input type="checkbox"/> Inadequate supervision
<input type="checkbox"/> Improper loading or placement	<input type="checkbox"/> Slippery conditions/uneven surface	<input type="checkbox"/> Insufficient job planning
<input type="checkbox"/> Improper lifting/moving	<input type="checkbox"/> Poor housekeeping	<input type="checkbox"/> Unrealistic scheduling
<input type="checkbox"/> Servicing/adjusting machinery in motion	<input type="checkbox"/> Excessive noise	<input type="checkbox"/> Inadequate workplace inspections
<input type="checkbox"/> Horseplay	<input type="checkbox"/> Inadequate guarding of hazards	<input type="checkbox"/> Poor process design
<input type="checkbox"/> Drug or alcohol use	<input type="checkbox"/> Defective tools/equipment	<input type="checkbox"/> Inadequate equipment
<input type="checkbox"/> Unsafe act(s) of other employees	<input type="checkbox"/> Insufficient lighting	<input type="checkbox"/> Unsafe design or construction
<input type="checkbox"/> Unnecessary haste/rushing	<input type="checkbox"/> Inadequate fall protection	<input type="checkbox"/> Unsafe/inadequate contractors
<input type="checkbox"/> Other: _____	<input type="checkbox"/> Other: _____	<input type="checkbox"/> Other: _____

**Is the activity that resulted in the incident routinely performed?    Yes    No**

### IV. CORRECTIVE ACTION: (Complete All sections)

List corrective action needed to prevent a recurrence	Responsible Person	Target Date	Completion Date

### V. WORKPLACE PRACTICES

**Include a copy of one of the workplace practices below for OSHA Recordable injuries:**  
 Job Hazard Analysis (JHA); Procedure; SOP; Manufacturer's Instructions that apply to the task that was performed.

**Comments:**

**Signature of person completing form:**

**Date:**

Supervisor    Employee    Witness

*Include photos, witness statement and any other relevant information*

# Treatment Authorization - FHQ

## U.S. HealthWorks

We are authorizing the below listed U.S. HealthWorks(s) to provide treatment to our employees. By doing so, we acknowledge that if the claim is denied by our insurance carrier, we will notify USHW of the denial and will be responsible for payment for all services rendered and any medically-necessary items dispensed.

**1 PRIMARY WORKERS' COMPENSATION CLINIC**

**U.S. HEALTHWORKS**

ORANGE – North Tustin St

1045 N Tustin St  
Orange CA 92867

Ph: (714) 288-8303

Fx: (714) 744-1991

M-F: 7:00 am – 6:00 pm

**2 Secondary Work Comp. Clinic**

**U.S. HealthWorks**

1619 E. Edinger Ave  
Santa Ana, CA 92705

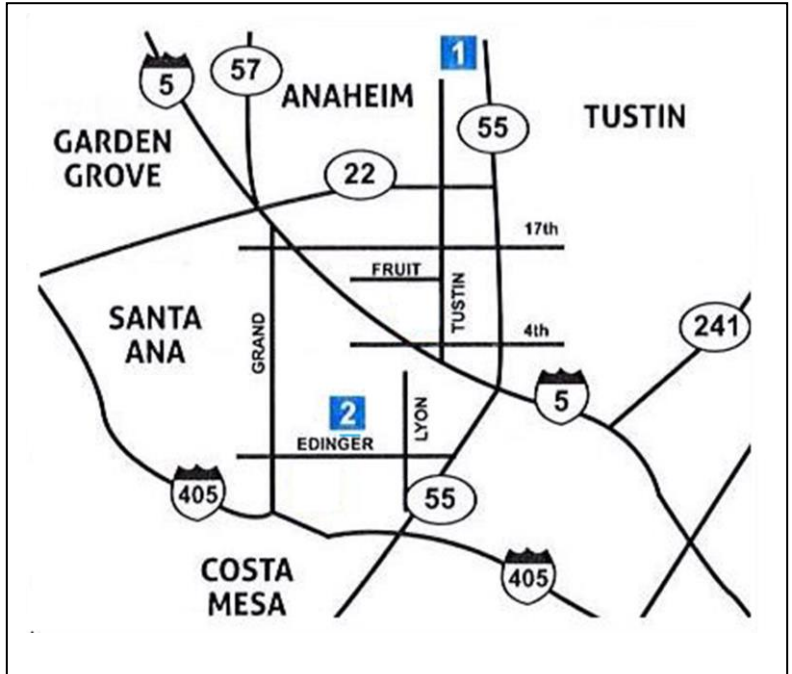
Ph: (714) 542-8904

Fx: (714) 541-5313

M-F: 7:00 am – 12:00 am

Sat 8am – 5pm

**24 hours for work injuries**



### Medical Services

- |                                                  |                                              |                                               |                                               |                                                      |
|--------------------------------------------------|----------------------------------------------|-----------------------------------------------|-----------------------------------------------|------------------------------------------------------|
| <input type="checkbox"/> Pre-Employment Physical | <input type="checkbox"/> DOT Physical        | <input type="checkbox"/> TB Test              | <input type="checkbox"/> Injury               | <input type="checkbox"/> Fit for Duty/Return to Work |
| <input type="checkbox"/> Drug Screen: DOT        | <input type="checkbox"/> Breath Alcohol Test | <input type="checkbox"/> Drug Screen: Non-DOT | <input type="checkbox"/> Reasonable Suspicion |                                                      |

**Medical Provider: OCWD has an aggressive Modified Duty program**

Patient's Name: \_\_\_\_\_

Date: \_\_\_\_\_ Time: \_\_\_\_\_ Date of Injury (If different from today): \_\_\_\_\_

Job Title: \_\_\_\_\_

Company Name: \_\_\_\_\_

Insurance Company: \_\_\_\_\_

Instructions: \_\_\_\_\_

Treatment Authorized By: \_\_\_\_\_  
(Print Name) (Signature)

Job Title: \_\_\_\_\_ Contact #: \_\_\_\_\_



**WORKERS' COMPENSATION CLAIM FORM (DWC 1)**

**PETITION DEL EMPLEADO PARA DE COMPENSACIÓN DEL TRABAJADOR (DWC 1)**

**Employee:** Complete the "Employee" section and give the form to your employer. Keep a copy and mark it "Employee's Temporary Receipt" until you receive the signed and dated copy from your employer. You may call the Division of Workers' Compensation and hear recorded information at (800) 736-7401. An explanation of workers' compensation benefits is included in the Notice of Potential Eligibility, which is the cover sheet of this form. Detach and save this notice for future reference.

You should also have received a pamphlet from your employer describing workers' compensation benefits and the procedures to obtain them. You may receive written notices from your employer or its claims administrator about your claim. If your claims administrator offers to send you notices electronically, and you agree to receive these notices only by email, please provide your email address below and check the appropriate box. If you later decide you want to receive the notices by mail, you must inform your employer in writing.

Any person who makes or causes to be made any knowingly false or fraudulent material statement or material representation for the purpose of obtaining or denying workers' compensation benefits or payments is guilty of a felony.

**Empleado:** Complete la sección "Empleado" y entregue la forma a su empleador. Quédese con la copia designada "Recibo Temporal del Empleado" hasta que Ud. reciba la copia firmada y fechada de su empleador. Ud. puede llamar a la División de Compensación al Trabajador al (800) 736-7401 para oír información gravada. Una explicación de los beneficios de compensación de trabajadores está incluido en la Notificación de Posible Elegibilidad, que es la hoja de portada de esta forma. Separe y guarde esta notificación como referencia para el futuro.

Ud. también debería haber recibido de su empleador un folleto describiendo los beneficios de compensación al trabajador lesionado y los procedimientos para obtenerlos. Es posible que reciba notificaciones escritas de su empleador o de su administrador de reclamos sobre su reclamo. Si su administrador de reclamos ofrece enviarle notificaciones electrónicamente, y usted acepta recibir estas notificaciones solo por correo electrónico, por favor proporcione su dirección de correo electrónico abajo y marque la caja apropiada. Si usted decide después que quiere recibir las notificaciones por correo, usted debe de informar a su empleador por escrito.

Toda aquella persona que a propósito haga o cause que se produzca cualquier declaración o representación material falsa o fraudulenta con el fin de obtener o negar beneficios o pagos de compensación a trabajadores lesionados es culpable de un crimen mayor "felonia".

**Employee—complete this section and see note above**

**Empleado—complete esta sección y note la notación arriba.**

1. Name. *Nombre.* \_\_\_\_\_ Today's Date. *Fecha de Hoy.* \_\_\_\_\_
2. Home Address. *Dirección Residencial.* \_\_\_\_\_
3. City. *Ciudad.* \_\_\_\_\_ State. *Estado.* \_\_\_\_\_ Zip. *Código Postal.* \_\_\_\_\_
4. Date of Injury. *Fecha de la lesión (accidente).* \_\_\_\_\_ Time of Injury. *Hora en que ocurrió.* \_\_\_\_\_ a.m. \_\_\_\_\_ p.m.
5. Address and description of where injury happened. *Dirección/lugar dónde ocurrió el accidente.* \_\_\_\_\_
6. Describe injury and part of body affected. *Describe la lesión y parte del cuerpo afectada.* \_\_\_\_\_
7. Social Security Number. *Número de Seguro Social del Empleado.* \_\_\_\_\_
8.  Check if you agree to receive notices about your claim by email only.  *Marque si usted acepta recibir notificaciones sobre su reclamo solo por correo electrónico.* Employee's e-mail. \_\_\_\_\_ *Correo electrónico del empleado.* \_\_\_\_\_  
You will receive benefit notices by regular mail if you do not choose, or your claims administrator does not offer, an electronic service option. *Usted recibirá notificaciones de beneficios por correo ordinario si usted no escoge, o su administrador de reclamos no le ofrece, una opción de servicio electrónico.*
9. Signature of employee. *Firma del empleado.* \_\_\_\_\_

**Employer—complete this section and see note below. Empleador—complete esta sección y note la notación abajo.**

10. Name of employer. *Nombre del empleador.* \_\_\_\_\_
11. Address. *Dirección.* \_\_\_\_\_
12. Date employer first knew of injury. *Fecha en que el empleador supo por primera vez de la lesión o accidente.* \_\_\_\_\_
13. Date claim form was provided to employee. *Fecha en que se le entregó al empleado la petición.* \_\_\_\_\_
14. Date employer received claim form. *Fecha en que el empleado devolvió la petición al empleador.* \_\_\_\_\_
15. Name and address of insurance carrier or adjusting agency. *Nombre y dirección de la compañía de seguros o agencia administradora de seguros.* \_\_\_\_\_
16. Insurance Policy Number. *El número de la póliza de Seguro.* \_\_\_\_\_
17. Signature of employer representative. *Firma del representante del empleador.* \_\_\_\_\_
18. Title. *Título.* \_\_\_\_\_ 19. Telephone. *Teléfono.* \_\_\_\_\_

**Employer:** You are required to date this form and provide copies to your insurer or claims administrator and to the employee, dependent or representative who filed the claim within **one working day** of receipt of the form from the employee.

SIGNING THIS FORM IS NOT AN ADMISSION OF LIABILITY

**Empleador:** Se requiere que Ud. feche esta forma y que provéa copias a su compañía de seguros, administrador de reclamos, o dependiente/representante de reclamos y al empleado que hayan presentado esta petición dentro del plazo de **un día hábil** desde el momento de haber sido recibida la forma del empleado.

EL FIRMAR ESTA FORMA NO SIGNIFICA ADMISION DE RESPONSABILIDAD

Employer copy/Copia del Empleador  Employee copy/Copia del Empleado  Claims Administrator/Administrador de Reclamos  Temporary Receipt/Recibo del Empleado