Orange County Water District

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: _____ ☐ a.m. ☐p.m.	Date of Report:	Time Employee Began Work: _____ ☐ a.m. ☐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

☐Allergic Reaction	☐Amputation	☐Burn	☐Chemical Exposure
☐Head Injury	☐Heat Related Illness	☐Laceration/Cut	☐Strain/Sprain

☐Other (please list):

Specific body part(s) injured:

MEDICAL CARE

☐First-Aid	☐Workers Comp Clinic	☐Emergency Room

WITNESSES

Any witnesses: ☐ Yes ☐ No	If yes, list witness(s) & include witness statement(s):

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

_____

☐ Supervisor ☐ Employee ☐ Witness

Date:

Include photos, witness statement and any other relevant information

Treatment Authorization - Fountain Valley

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

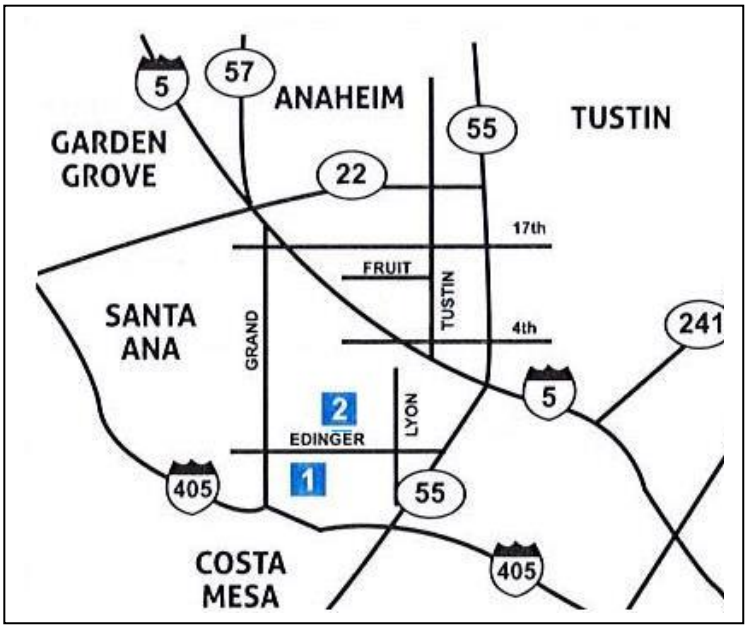
M-F: 8:00 am – 6:00 pm

1530 E Edinger Ave, Santa Ana, CA 92705
Ph: (714) 541-8464
Fx: (714) 541-8461

2 Secondary Workers' Compensation Clinic

Afterhours & Weekend: 24 Hrs. for Work-Related Injuries

1619 E. Edinger Ave
Santa Ana, CA 92705
Ph: (714) 542-8904
Fx: (714) 541-5313



Medical Services

☐ Pre-Employment Physical ☐ DOT Physical ☐ TB Test ☐ Injury ☐ Fit for Duty/Return to Work

☐ Drug Screen: DOT ☐ Breath Alcohol Test ☐ Drug Screen: Non-DOT ☐ 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: Orange County Water District (OCWD)

Insurance Company: ACWA/JPIA, P.O. Box 619802, Roseville, CA 95681-9082. Bill OCWD for First Aid injuries

Instructions: _____

Treatment Authorized By: _____ _____
(Print Name) (Signature)

Job Title: _____ Contact #: _____

PRINT CLEAR

State of California
Department of Industrial Relations
DIVISION OF WORKERS' COMPENSATION

Estado de California
Departamento de Relaciones Industriales
DIVISION DE COMPENSACIÓN AL TRABAJADOR

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 Division de Compensación al Trabajador al* ***(800) 736-7401*** *para oir 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 benficios 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 occurió el accidente.* _____
_____
6. Describe injury and part of body affected. *Describa 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.* **Orange County Water District (OCWD)**
11. Address. *Dirección.* **18700 Ward Street, Foutain Valley, CA 92708**
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 adminstradora de seguros.* _____
ACWA JPIA, P.O. Box 619802, Roseville, CA 95681-9082
16. Insurance Policy Number. *El número de la póliza de Seguro.*_____ **Permissibly Self Insured**
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*