

**Environmental Health & Safety**

**EMPLOYEE’S FIRST REPORT OF INJURY FORM**

INSTRUCTIONS Using this form, employees shall report all work-related accidents, injuries, illnesses, or unplanned events which could have resulted in an injury or illness. Once completed, email this form to [workerscomp@ucr.edu](mailto:workerscomp@ucr.edu) or fax to 951-827-3202.

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| --- | --- | --- | --- | --- | --- | --- |
| I AM REPORTING A WORK RELATED: |  | INJURY |  | ILLNESS |  | NEAR MISS |

|  |  |  |  |
| --- | --- | --- | --- |
| YOUR NAME | YOUR HOME DEPARTMENT NAME | DATE OF REPORT | |
|  |  | |  |
| JOB TITLE | SUPERVISOR NAME | | |
|  |  | | |

|  |  |  |
| --- | --- | --- |
| LOCATION OF INCIDENT | DATE OF INCIDENT | TIME |
|  |  |  |
| WITNESSES *if any* | | |
|  | | |
| INCIDENT DESCRIPTION Describe tasks being performed and sequence of events. *Attach additional pages as necessary.* | | |
|  | | |
| What parts of your body were injured? If a near miss, how could you have been hurt? | | |
|  | | |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Was medical treatment necessary? | | | | IF YES, NAME OF HOSPITAL / PHYSICIAN: |
|  | YES |  | NO |  |
| DATE OF VISIT | | TIME OF VISIT | | HOSPITAL / PHYSICIAN PHONE |
|  | |  | |  |

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| Do you have other employment? |  | YES |  | NO | Company Name |  |

|  |  |  |  |
| --- | --- | --- | --- |
| **EMPLOYEE SIGNATURE** | **DATE** | **SUPERVISOR SIGNATURE** | **DATE** |
|  |  |  |  |