EMPLOYEE'S REPORT OF INJURY

HIRE DATE: _________

EMPLOYEE LAST NAME: ______________________________ FIRST NAME: _____________________ SSN:________________

HOME ADDRESS: ______________________________ CITY: ______________________ STATE: _________ ZIP: ____________

PHONE NUMBER: ____________________________ DATE OF BIRTH: ______________________

ANY PRE-EXSTING CONDITIONS? YES NO IF YES, EXPLAIN: ____

HAVE YOU HAD A PREVIOUS WORKERS COMP CLAIM? YES NO

IF YES, PLEASE EXPLAIN:____

DATE OF INJURY: ________________ TIME OF INJURY: ______________

INJURY REPORTED TO: ________________________ DATE REPORTED: ________________ JOB TITLE: ________________

JOB DUTIES: ____________________________________

WHERE DID INJURY OCCUR?

____

WHAT CAUSED THE INJURY?:____

WHAT COULD HAVE BEEN DONE TO PREVENT INJURY?: ____

NATURE OF INJURY: ________________________________

PART OF BODY INJURED: _________________________________

WHO WITNESSED THE INCIDENT?

____

WAS THERE ANY INVOLVEMENT BY THIRD PARTY CONTRIBUTING TO THE CAUSE OF THE INCIDENT? YES NO

IF YES, PLEASE EXPLAIN:____

WERE ALL SAFETY GUIDELINES FOLLOWED? YES NO

DID YOU RECEIVE TREATMENT FOR INJURY? YES NO

CLINIC NAME:____

ADDRESS: __________________________________ PHONE: _______________ LAST DAY WORKED:_____________________

DATE RETURNED TO WORK: ____________ CAN YOU WORK MODIFIED DUTY? YES NO

EMPLOYEE SIGNATURE:____ DATE:_____________________

NOTE: Any person who knowingly provides false, incomplete or misleading information to any party for the purpose of obtaining workers' compensation benefits is guilty of a felony and may be subject to imprisonment, fines, and denial of insurance benefits.

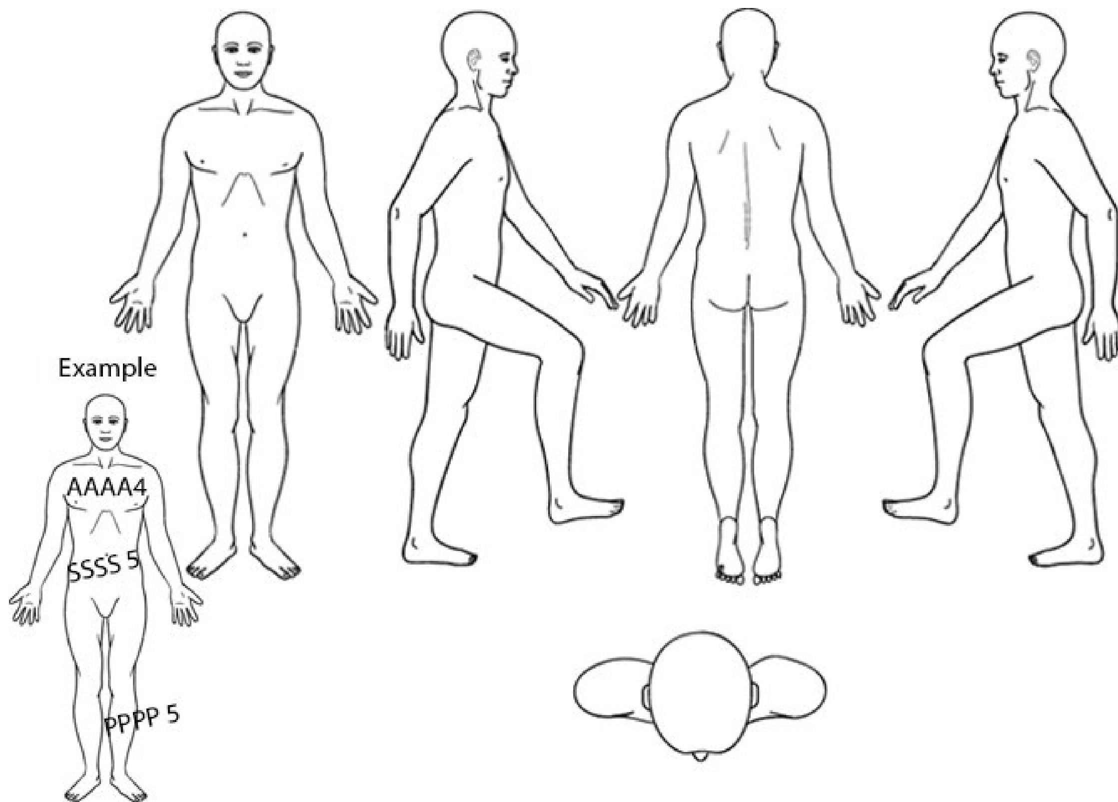
Pain chart:

Please mark area(s) of injury or discomfort as shown in the example below. Mark all areas with the appropriate symbols and indicate the degree of pain using a scale from 1 (discomfort) to 10 (extreme pain)

Description:	Numbness	Pins & Needles	Burning	Aching	Stabbing
Symbol:	NNNN	PPPP	BBBB	AAAA	SSSS

Nature of injury: (most serious one)

- ☐ Abrasion, scrapes ☐ Amputation ☐ Broken bone ☐ Bruise
- ☐ Burn (heat) ☐ Burn (chemical) ☐ Concussion (to the head) ☐ Crushing Injury
- ☐ Cut, laceration, puncture ☐ Hernia ☐ Illness ☐ Sprain, strain
- ☐ Damage to a body system: (e.g. nervous, respiratory, or circulatory system):
- ☐ Other:



WHAT COULD HAVE BEEN DONE TO PREVENT INJURY:

Note: Any person who knowingly provides false, incomplete, or misleading information to any party for the purpose of obtaining workers' compensation benefits is guilty of a felony and may be subject to imprisonment, fines, and denial of insurance benefits.

Employee Name (Print)

Date:

Employee Signature

PLEASE SUBMIT FORM TO COMPANY MANAGER OR SUPERVISOR

Consent for Release of Medical Information

Employee

I hereby authorize representatives of UCP Personnel to be permitted to obtain and review copies of all medical records related to any current or past injury or related to my medical history. Any pertinent information will be discussed with other professionals involved in my medical treatment and any institution that, through the "Workers' Compensation Program" or otherwise, is paying all or part of the costs associated with my medical care.

____
Employee's Printed Name

____
Social Security Number

____
Telephone Number

____
Claim Number

____
Name of Employer

____
Date of Injury

Employee's Signature_____________________________ Date: ___________________________

If you have any questions or concerns, please feel free to contact your primary UCP contact.

SUPERVISOR/EMPLOYER'S REPORT OF INJURY

HIRE DATE : _________

COMPANY NAME: ________________________________

EMPLOYEE LAST NAME: ____________________________ FIRST NAME: ___________________ SSN:_______________

HOME ADDRESS: ____________________________ CITY: ____________________ STATE: ________ ZIP:___________

PHONE NUMBER: __________________________ DATE OF BIRTH: _____________________

ANY PRE-EXSTING CONDITIONS? Y N IF YES, EXPLAIN: _______________________________________

DATE OF INJURY: _______________ TIME OF INJURY: _____________ DATE EMPLOYER NOTIFIED: ___________________

EMPLOYEE JOB DUTIES AT TIME OF INJURY:____ CLASS CODE: __________

WAS EMPLOYEE PERFORMING ASSIGNED JOB DUTIES AT TIME OF INJURY? Y N

IF NOT, WHO ASSIGNED ALTERNATE TASK/DUTIES?____

CLIENT LOCATION NAME: _______________________ LOCATION ADDRESS: ____________________________________

DESCRIPTION OF CLIENT OPERATIONS:____

DESCRIPTION OF INCIDENT: ____

____

NATURE OF INJURY: ______________________________ PART OF BODY INJURED: ______________________________

LAST DAY WORKED: _____________ DATE RETURNED TO WORK: ____________ IS LIGHT DUTY AVAILALBLE? Y N

WAS EMPLOYEE PAID FOR FULL DAY ON DAY OF INJURY? Y N

CLINIC NAME: _______________________ ADDRESS: ________________________________ PHONE: ______________

WAS DRUG TEST ADMINISTERED? Y N

DID THE EMPLOYEE APPEAR TO BE UNDER THE INFLUENCE? Y N

IS CLAIM QUESTIONED? Y N

WITNESSES? Y N

WAS THERE ANY INVOLVEMENT BY THIRD PARTY CONTRIBUTING TO THE CAUSE OF THE INCIDENT? Y N

IF YES, PLEASE PROVIDE NAMES:____

WERE SAEFTY PROTOCOLS FOLLOWED?: Y N

HAS EMPLOYEE BEEN RECENTLY DISCIPLINED? Y N

SIGNATURE OF SUPERVISOR/MANAGER:____ DATE:_________________

If you have any questions or concerns, please feel free to contact your primary UCP contact.

WORKERS COMPENSATION – FIRST REPORT OF INJURY OR ILLNESS

EMPLOYER (NAME & ADDRESS INCL ZIP)	CARRIER/ADMINISTRATOR CLAIM NUMBER	OSHA LOG NUMBER	REPORT PURPOSE CODE
	JURISDICTION	JURISDICTION CLAIM NUMBER	
	INSURED REPORT NUMBER		
	EMPLOYER'S LOCATION ADDRESS (IF DIFFERENT)		LOCATION #
INDUSTRY CODE / EMPLOYER FEIN			PHONE #

CARRIER/CLAIMS ADMINISTRATOR

CARRIER (NAME, ADDRESS, & PHONE #)	POLICY PERIOD TO CHECK IF APPROPRIATE SELF INSURANCE	CLAIMS ADMINISTRATOR (NAME, ADDRESS & PHONE NO)
CARRIER FEIN	POLICY/SELF-INSURED NUMBER	ADMINISTRATOR FEIN

EMPLOYEE/WAGE

NAME (LAST, FIRST, MIDDLE)	DATE OF BIRTH	SOCIAL SECURITY NUMBER	DATE HIRED	STATE OF HIRE
ADDRESS (INCL ZIP)	SEX M MALE F FEMALE U UNKNOWN	MARITAL STATUS U UNMARRIED M MARRIED S SEPARATED K UNKNOWN	OCCUPATION/JOB TITLE EMPLOYMENT STATUS	
PHONE	# OF DEPENDENTS		NCCI CLASS CODE	

RATE PER:	DAY / WEEK	MONTH / OTHER:	DAYS WORKED/WEEK	FULL PAY FOR DAY OF INJURY? YES NO DID SALARY CONTINUE? YES NO

OCCURRENCE/TREATMENT

Time Employee Began Work AM PM	DATE OF INJURY/ILLNESS	TIME OF OCCURRENCE AM PM ( ) CANNOT BE DETERMINED	LAST WORK DATE	DATE EMPLOYER NOTIFIED	DATE DISABILITY BEGAN

CONTACT NAME/PHONE NUMBER	TYPE OF INJURY/ILLNESS	PART OF BODY AFFECTED
DID INJURY/ILLNESS/EXPOSURE OCCUR ON EMPLOTERS PREMISES? YES NO	TYPE OF INJURY/ILLNESS CODE	PART OF BODY AFFECTED CODED

DEPRATMENT OR LOCATION WHERE ACCIDENT OR ILLNESS EXPOSURE OCCUPIED	ALL EQUIPMENT, MATERIALS, OR CHEMICALS EMPLOYEE WAS USING WHEN ACCIDENT OR ILLLNESS EXPOSURE OCCURED
SPECIFIC ACTIVITY THE EMPLOYEE WAS ENGAGED IN WHEN THE ACCIDENT OR ILLNESS EXPOSURE OCCURRED	WORK PROCESS THE EMPLOYEE WAS ENGAGED IN WHEN ACCIDENT OR ILLNESS EXPOSURE OCCURRED

HOW INJURY OR ILLNESS/ABNORMAL HEALTH CONDITION OCCURRED. DESCRIBE THE SEQUENCE OF EVENTS AND INCLUDE ANY OBJECTS OR SUBSTANCES THAT DIRECTLY INJURED THE EMPLOYEE OR MADE THE EMPLOYEE ILL

CAUSE OF INJURY CODE

DATE RETURN(ED) TO WORK	IF FATAL, GIVE DATE OF DEATH	WERE SAFEGUARDS OR SAFETY EQUIPMENT PROVIDED? YES NO WERE THEY USED? YES NO

PHYSICIAN/HEALTH CARE PROVIDER (NAME & ADDRESS)	HOSPITAL OR OFF SITE TREATMENT (NAME & ADDRESS)	INITIAL TREATMENT 0 NO MEDICAL TREATMENT 1 MINOR: BY EMPLOYER 2 MINOR CLINIC/HOSP 3 EMERGENCY CARE 4 HOSPITALIZED > 24 HOURS 5 FUTURE MAJOR MEDICAL/ LOST TIME ANTICIPATED

OTHER

WITNESSES (NAME & PHONE #)

DATE ADMINISTRATOR NOTIFIED	DATE PREPARED	PREPARER'S NAME & TITLE	PHONE NUMBER

Worker's Compensation Employee Job Description

Name of Company:____

Name of the Employee: _________________________ Date of Hire: _____________________

Name of Worksite Location: ____

Address of Work Site Location:____

Assigned Department: ____

Detail Job Duties: ____

____

Physical demands/requirements of position:

Weight of material push/pulled/lift/carry: >0-5 lbs >5-10 lbs >10-20lbs

>20-30 lbs >30-50 lbs >50+ lbs

Safety Equipment Used/Required: EYE WEAR STEEL TOE BOOTS

GLOVES HARD HAT HARNESS MACHINE GAURDS

LOTO TRAINING FORKLIFT CERTFIFIED

OTHER: ____

Name of Supervisor at time of Injury: ____

Signature of Supervisor: ___________________________________ Date: _______________________

NOTE: Any person who knowingly provides false, incomplete or misleading information to any party for the purpose of obtaining workers' compensation benefits is guilty of a felony and may be subject to imprisonment, fines, and denial of insurance benefits.

Please email signed form to your primary contact at UCP.

Accident Investigation Report

Please complete this form as soon as possible after an incident that results in serious injury or illness occurs. (Optional: Use to investigate a minor injury or near miss that could have resulted in a serious injury or illness.)

This is a report of a: Death Lost Time Dr. Visit Only First Aid Only Near Miss

Date of Incident: ____________________

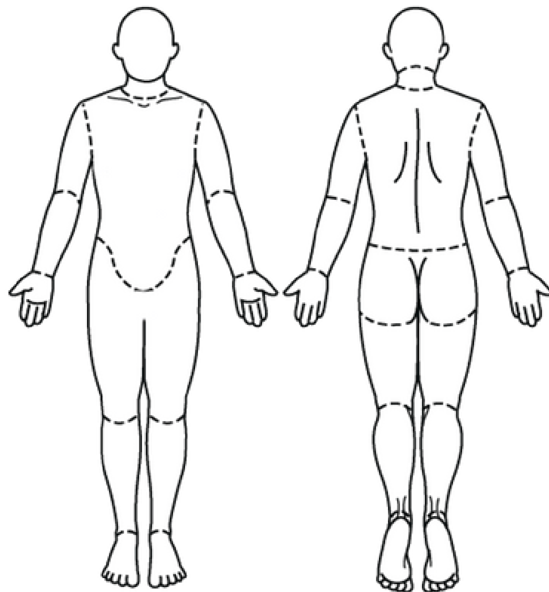
Step 1: Complete this part for each Injured Employee

Company Name

Injured Employee Name: **Sex:** **Male** **Female** **Age:**

Department: **Job title at time of incident:**

Part of body affected: (shade all that apply)



Nature of injury:

(most serious one)

Abrasion, scrapes
Amputation
Broken bone
Bruise
Burn (heat)
Burn (chemical)
Concussion (to the head)
Crushing Injury
Cut, laceration, puncture
Hernia
Illness
Sprain, strain
Damage to a body system: (e.g. nervous, respiratory or circulatory system)
Other:

This employee works:

Regular Full-Time
Regular Part-Time
Seasonal
Temporary

Months with this employer:

Months doing this job:

Step 2: Describe the Incident

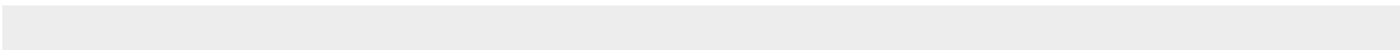
Address of where the incident occured:

City: **State:** **Zip Code:**

Exact location of the incident: **Exact Time: AM PM**

What part of employee's workday: Entering or leaving work Doing normal work activities During break Doing normal work activities During meal period Working overtime Other

Name of Witness(es)



Accident Investigation Report

Step 3: Why did the incident happen?

Unsafe workplace conditions: (Check all that apply)

- Inadequate guard
- Unguarded hazard
- Safety device is defective
- Tool or equipment defective
- Workstation layout is hazardous
- Unsafe lighting
- Unsafe ventilation
- Lack of needed personal protective equipment
- Lack of appropriate equipment/tools
- Unsafe clothing
- Other:

Unsafe acts by people: (Check all that apply)

- Operating without permission
- Operating at unsafe speed
- Servicing equipment that has power to it
- Making a safety device inoperative
- Using defective equipment
- Unsafe lifting by hand
- Taking an unsafe position or posture
- Distraction, teasing, horseplay
- Failure to wear personal protective equipment
- Failure to use the available equipment/tools
- Other:

Why did the unsafe conditions exist? ______________________________

____

Why did the unsafe acts occur?______________________________

____

Was there a basis (such as “the job can be done more quickly” or “the product is less likely to be damaged”) that may have encouraged the unsafe conditions or acts? Yes No

If yes, describe: ______________________________

____

Where the unsafe acts or conditions reported prior to the incident? Yes No

Have there been similar incidents or near misses prior to this one? Yes No

Step 4: How can future incidents be prevented?

What changes: Stop this activity Guard the hazard Train the employee(s) Train the supervisor(s) Redesign task steps Redesign work station Write a new policy/rule Enforce existing policy Routinely inspect for the hazard Personal Protective Equipment Other:

What should be (or has been) done to carry out the suggestion(s) checked above?

____

____

____

____

Accident Investigation Report

Step 5: Who completed and reviewed this form? (Please Print)

Written by: ______________________________ **Title:** ______________________________

Department: ______________________________ **Date:** ______________________________

Names of investigation team members:

____

____

____

____

Reviewed by: ______________________________ **Title:** ______________________________

Date: ______________________________