

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 IF YES, PLEASE EXPLAIN:		
DATE OF INJURY:TIM	1E OF INJURY:	
INJURY REPORTED TO:	DATE REPORTED:	JOB TITLE:
JOB DUTIES:		
WHERE DID INJURY OCCUR?		
WHAT COULD HAVE BEEN DONE TO PREV	ENT INJURY?:	
NATURE OF INJURY:		
PART OF BODY INJURED:		
WHO WITNESSED THE INCIDENT?		
WAS THERE ANY INVOLVEMENT BY THIRE IF YES, PLEASE EXPLAIN:	D PARTY CONTRIBUTING TO THE	CAUSE OF THE INCIDENT? YES NO
WERE ALL SAFETY GUIDELINES FOLLOWE		
DID YOU RECEIVE TREATMENT FOR INJUI	RY? YES NO	
CLINIC NAME:		
ADDRESS:	PHONE:	LAST DAY WORKED:
DATE RETURNED TO WORK:	_ CAN YOU WORK MODIFIED DU	TY? 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)

symbols and indica	te the degree of բ	pain using a scale from	1 (discomfort) to 10 (extrer	ne pain)			
Description:	Numbness	Pins & Needles	Burning	Aching	Stabbing			
Symbol:	NNNN	PPPP	BBBB	AAAA	SSSS			
lature of injury: (most serious one)								
Abrasion, scrape	es 🔲 Amp	outation Broker	n bone	Bruis	е			
Burn (heat)			ssion (to the h	ead) Crush	ing Injury			
Cut, laceration,					n, strain			
	dy system: (e.g. n	ervous, respiratory, or	circulatory sy	stem):				
Other:								
A. A. S.	ample AAA4 SSS 5 LD HAVE BEEN I	DONE TO PREVENT I	NJURY:					
Note: Any pers	on who knowingly pr	ovidas falsa, incomplata, on	· mislaadina info	rmation to any n	arty for the purpose of obtaining			
					arty for the purpose of obtaining all denial of insurance benefits.			

Employee Signature

Employee Name (Print)

Date:



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:	S	SN:
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: DAT	ΓΕ EMPLOYER NOTIFIED: _	
EMPLOYEE JOB DUTIES AT TIME OF INJUR	łΥ:	CL#	SS CODE:
WAS EMPLOYEE PERFORMING ASSIGNED 3	JOB DUTIES AT TIME OF INJURY?	Y N	
IF NOT, WHO ASSIGNED ALTERNATE TASK	/DUTIES?		
CLIENT LOCATION NAME:			
DESCRIPTION OF CLIENT OPERATIONS:			
DESCRIPTION OF INCIDENT:			
NATURE OF INJURY:			
LAST DAY WORKED: DAT	E RETURNED TO WORK:	IS LIGHT DUTY AVA	ILALBLE? Y N
WAS EMPLOYEE PAID FOR FULL DAY ON DA			
CLINIC NAME:	ADDRESS:	PH(ONE:
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 CA	USE OF THE INCIDENT?	Y N
IF YES, PLEASE PROVIDE NAMES:			
WERE SAEFTY PROTOCOLS FOLLOWED?:	Y N		
HAS EMPLOYEE BEEN RECENTLY DISCIPLI	NED? 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

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FORM IA-1(r 1-1-02) IAIABC 2002



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 BO	OTS	
GLOVES HARD HAT HARNESS	MACHINE GAU	RDS	
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:

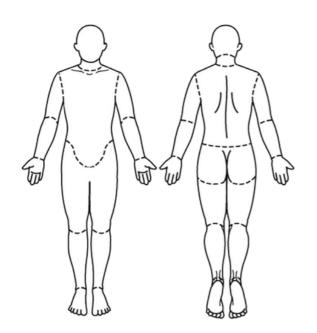
Step 1: Complete this part for each Injured Employee

Company Name

Injured Employee Name: Sex: Male Female Age:

Department:

Part of body affected: (shade all that apply)



Job title at time of incident: 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:

Doing normal work activities During break

Step 2: Describe the Incident

Address of where the incident occured:

Citv: State: Zip Code:

Exact location of the incident: Exact Time: AM PM

What part of employee's workday:

During meal period Working overtime Other Doing normal work activities

Entering or leaving work

Name of Witness(es)



Accident Investigation Report

Step 3: Why did the incident happen?

ACCIDENT INVESTIGATION

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 Operating without permission Operating at unsafe speed Servicing equipment that has possible as a safety device inoperation. Using defective equipment Unsafe lifting by hand Taking an unsafe position or possible between Distraction, teasing, horseplay Failure to wear personal protection. Failure to use the available equip Other:	wer to it ve ture ve equipment
Why did the unsafe conditions exist?	otilei.	
willy did the disale conditions exist?		
Why did the unsafe acts occur?		
that may have encouraged the unsafe conditions or actification of the second sec	cts? Yes No	
Where the unsafe acts or conditions reported prior to	the incident? Yes No	
Have there been similar incidents or near misses prio	r to this one? Yes No	
Step 4: How can future incidents be prevented?		
What changes: Stop this activity Guard the haz Redesign task steps Redesign work station V Routinely inspect for the hazard Personal Pro		Train the supervisor(s) Enforce existing policy
What should be (or has been) done to carry out the su	ggestion(s) checked above?	



Accident Investigation Report

Step 5: Who completed and reviewed this form? (Please Print)					
Written by:	Title:				
Department: Names of investigation team members:	Date:				
Reviewed by:	Title:				
	Date:				