

USC Supervisor's Report of Incident

FOR QUESTIONS, PLEASE CALL THE WORKERS' COMPENSATION DEPARTMENT (213) 740-6205.

Complete this form and send IMMEDIATELY to the Worker's Compensation Office, answer every question fully.
Benefits CANNOT be paid until all required information is received.

Submit this form whether or not the injured person receives medical care or the injury seems trivial.

EMPLOYEE INFORMATION

Name _____ Employee ID# _____
Address _____ City _____ State _____ Zip _____
Date of Birth _____ Male Female Home Phone Number (_____) _____ - _____
Department _____ Job Title _____
Work Address _____ Work Phone Number (_____) _____ - _____
Work _____ hours/day for _____ days/week. Full-time Work-study Casual
Date of Hire _____ Years in this occupation _____
List any concurrent employment _____

EXACT LOCATION OF INCIDENT

Bldg./Room _____ Address _____
Date of accident/illness _____ Hour _____ a.m. p.m. Time employee began work _____ a.m. p.m.
Date Reported to Supervisor _____ Time _____ a.m. _____ p.m.

SUPERVISOR'S INVESTIGATION OF INCIDENT

Describe what employee was doing just before the incident occurred (Include **activity** and any **tools, equipment, material** used; e.g. "using knife to cut lettuce for salad") _____

Describe how accident occurred (e.g. "knife slipped and cut finger") _____

Type of injury **and** part of body affected (e.g. "laceration to left index finger") _____

List object, tool or substance that was most clearly connected with the accident/illness (e.g. knife, stairs, floor) _____

Names and addresses of any witnesses, or the person responsible for the injury/illness _____

Were safeguards provided? _____ If yes, was employee using them at the time of injury? _____

Preventive recommendations and corrective actions _____

For Sharps Injuries only: Brand _____ Model _____
Sharps protection activated? _____ If yes, before injury _____ during injury _____ after injury _____
If no, explain _____
Please complete Sharps Injury Form, available online at <http://capsnet.usc.edu/WC/index.cfm>

TREATMENT INFORMATION

Treatment given at: Student Health Center Internal Medicine (HCC II) Emergency Room Hospitalization

If treated by Physician for this injury please list name and address _____

Address of off campus physician _____

Days off work? _____ Was injured paid in full for those days? _____ Sick time Vacation

Has employee returned to work? _____ If yes, give date _____

Is modified work available? _____ If yes, for how long? _____ If **no time lost**, check here

Supervisor's name (PRINT OR TYPE) _____ Ext. _____ Date _____

Department Head's Signature _____ Date _____

Forward all paperwork to:

Career and Protective Services, Workers' Compensation, Hazel Stanley Hall-300, Mail Code 1058, Fax: 213-740-7305

ATTACH EMPLOYEE'S CLAIM FOR WORKER'S COMPENSATION BENEFITS FORM

Keep a copy of this report in the Employee's file. Contact Worker's Compensation Office at (213) 740-6205 for assistance.

Additional forms are available online at <http://capsnet.usc.edu/WC/index.cfm>