

INJURY AND ILLNESS – INVESTIGATION REPORT

Supervisors: Notify Human Resources/Workers' Compensation (HR-WC) immediately of all injuries to covered employees. Complete the "Injury and Illness Investigation Report" faxing a preliminary copy to HR-WC. Provide original to Department/Division Head for signature copy HR when signed. (2) Report all serious or fatal on-the-job injuries to Cal/OSHA by calling 916-263-2800, within 8 hours of occurrence and notify HR-WC and CEO-Safety. Serious injury or illness includes an amputation of a part of the body, disfigurement, or in-patient hospitalization for more than 24 hours for other than observation. (3) provide a DWC-1 to injured worker w/n 24 hours of first knowledge. Enter name on line 1, copy, or use Acknowledgment Form. Resources: MyPlacer/Human Resources/Workers' Compensation, and MyPlacer CEO, Safety.

Please check box below: Due within 2 working days - HR-Worker's Comp: 530.889.4060, or 530.886.2606/2611 - Fax: 530.886.4609

Injury report only – not seeking Workers' Compensation benefits **First Aid only no outside care**

Requesting Workers' Compensation benefits. Supervisor provide the "Employees' Claim for Workers' Compensation Benefits" - "DWC -1" and retain a copy for HR-WC.

Information about the Injured Worker

County Employee Inmate Work Release Volunteer Private Citizen

1. Full Name: _____

2. Department: _____ 3. Division: _____

4. Home Address: _____ 5. City: _____ 6. State: _____ 7. Zip: _____

8. Date of Birth: _____ 9. Date Hired: _____ 10. Home Ph. #: _____

Male Female 11. Employee Number: _____ 12. Job Title: _____

Location Where Employee is Based: Auburn Colfax Foresthill Lake Tahoe Other
 Lincoln Loomis Rocklin Roseville

Information about the doctor if seen for this incident

If necessary, direct or provide transportation for the injured worker to County-approved medical facilities posted on our website and MyPlacer). In the event of a serious injury, the closest Emergency Room or Urgent Care Facility may be used. If an employee has already provided HR written notice designating the primary care medical doctor for workers' compensation injuries, the employee may seek treatment from that doctor. Chiropractors may not be designated for this purpose.

13. Injured worker referred to which medical facility? Facility Name: _____
 Street: _____ City _____ State: _____ Zip: _____

14. Was First-Aid treatment provided? Yes No

15. Was employee treated in an emergency room? Yes No

16. Was employee hospitalized more than 24 hours? Yes No If yes, Cal/OSHA must be notified within 8 hours.

Information about the injury or illness

17. Date of Injury: _____ 18. Time of Event: _____ a.m. p.m.

19. Time employee began work: _____ a.m. p.m.

20. Date/Time Reported: _____ a.m. p.m.

21. Work Schedule – Days & Hours Worked: _____
 Full Time Part Time Temp Extra Help 22. Hours Worked per Pay Period? _____

23. Restricted work provided?: Yes No 24. Date and Time: _____ a.m. p.m.

25. Directed to leave work? Yes No 26. Date and Time: _____ a.m. p.m.

27. Returned to work?: Yes No 28. Date and Time: _____ a.m. p.m.

29. Property damage?: Yes No 30. Third Party Involved?: Yes No

31. Actual lost work days: _____

32. Address where injured: _____

33. Case number from OSHA Log (N/A) _____ (HR-WC will transfer case # if applicable)

34. **What was the employee doing just before the incident occurred?** Describe the activity, as well as the tools, equipment, or material the employee was using. Be specific. Examples: "climbing a ladder while carrying roofing materials"; "spraying chlorine from hand sprayer"; "daily computer key-entry."

35. **What happened?** Tell us how the injury occurred. Examples: "When ladders slipped on wet floor, worker fell 20 feet"; "worker was sprayed with chlorine when gasket broke during replacement"; "Worker developed soreness in right and left wrists over time."

36. **What was the injury or illness?** Tell us the part of the body that was affected and how it was affected; be more specific than "hurt", "pain", or "sore". Examples: "strained back"; "chemical burn, right hand"; "carpal tunnel syndrome".

37. **What object or substance directly harmed the employee?** Examples: "concrete floor", "chlorine"; "radial arm saw." If this question does not apply, leave it blank.

38. **Cause of unsafe act** (Mandatory):

39. **Corrective action** to prevent recurrence (Mandatory):

40. **If the employee died, when did the death occur?** Date and time of death: _____ a.m. p.m.

41. **Names and phone number(s) of witness(es)** – attach any witness statements on a separate sheet of paper.

Completed by: (print name) _____ Phone: _____

Signature: _____ Date: _____

Department Head (print name) _____ Phone _____

Department Head Signature: _____ Date _____

Attention: This form contains information relating to employee health and must be used in a manner that protects the confidentiality of employees to the extent possible while the information is being used for occupational safety and health purposes. See CCR Title 8 14300.29(b)(6)-(10)