Manager's Report of Incident Form

Manager (or other department representative) must complete this form for all work-related incidents whether an employee seeks medical care or not. Answer each question fully. Failure to submit this information in a timely manner will delay benefits.

HR Partner should then submit this form, with completed Workers' Compensation Claim Form (DWC-1), to USC Disability Management via fax *(213) 740-7305*. Keep a copy for home department records.

Employee information

Name (first and last) **Employee ID number** (either 7 or 10 digits)

Date of birth (mm/dd/yyyy) **Gender** **Phone number**

Address **City** **State** **Zip**

Occupation (regular job title, no initials, abbreviations or numbers) **Date of hire** (mm/dd/yyyy)

Employee usually works ____ hours per day, ____ days per week, ____ total weekly hours

Employment status:

☐ **regular, full time** ☐ **part-time** ☐ **temporary** ☐ **seasonal**

Gross wages/salary ___________ **per** _________

Other payments not reported as wages/salary (for example, tips, meals, overtime, bonuses, etc.)**?** ☐ **Yes** ☐ **No**

List any concurrent employment

Incident information

Location of incident (building and room)

Address

Date of incident (mm/dd/yyyy) **Time of incident (hh:mm)** **Time employee began work (hh:mm)**

Date incident was reported to manager (mm/dd/yyyy) **Time of report (hh:mm)**

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

Manager's Report of Incident Form

Incident information (continued)

Describe how accident occurred. Indicate injured body part or illness involved (for example, "knife slipped and cut left index finger")

Indicate name and contact information of any 3rd party responsible for the incident, if applicable (person or company)

List names and contact information of any witnesses

Was work time lost as a result of this incident? ☐ Yes ☐ No

Has employee returned to work? ☐ Yes ☐ No **If yes, when?** ___ / ___ / ______ (mm/dd/yyyy)

Is modified work available? ☐ Yes ☐ No **If yes, for how long?** ________________

For needle sticks only

Brand **Model**

Was the sharps protection activated? ☐ Yes ☐ No

If yes, when? ☐ before injury ☐ during injury ☐ after injury

If no, explain

Treatment information

Treatment provided by

☐ Engemann Student Health Center ☐ Internal Medicine (HCC II)

☐ emergency room ☐ hospitalization ☐ other

List name and address of physician who administered treatment, if applicable

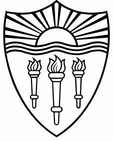
Declination of medical treatment

☐ **Employee declined medical treatment. Ensure employee signs the declination of workers' compensation form.**

Manager signature

Manager's signature **Date** (mm/dd/yyyy)

Manager's employee ID number **Phone extension**



USC University of Southern California

Complete only if employee declined medical treatment

Date:

Employee Name:

Street:

City: State: Zip:

Re: Workers' Compensation Injury

Dear ,

DECLINATION OF WORKERS' COMPENSATION BENEFITS AND MEDICAL TREATMENT

I, _________________________________ decline medical treatment for injury/illness I incurred
(Employee)
on ______________________. I understand that I may be entitled to workers' compensation benefits,
(Date)
examination and/or treatment as a result of my work injury/illness.

I understand this declination is a voluntary decision and does not waive my rights under Workers Compensation Benefits as set forth by the State.

I agree to notify my manager immediately should I need to seek medical treatment for this injury/Illness at a later time.

Comments:

____

____

____

____
Employee Signature

____
Authorized Employer Signature

____
Date

Employee: Please return this form to your Home Department
Employer: Please place in Employee's Personnel file
cc: Disability Management Office