Reset Form

CITY OF CHICO – INCIDENT REPORT ❑ Declined Medical Treatment ❑ Requested/Received Medical Treatment

EMPLOYEE PORTION

Employee Name:	Job Title:	Department:	Employee #:

Home Address:	Phone Number:

Date of Birth:	Gender: ❑ Male ❑ Female	Date of Hire:	Shift, Work Days, Hours Per Day:	Shift Start Time:

Incident Date:	Incident Time:	Location of Incident:

Date Reported:	Reported To (Name, Job Title):	Date Claim Form Provided:

Incident Classification: (select all that apply) ❑ Fall ❑ Lifting ❑ Exposure ❑ Caught In/Between ❑ Trip/Slip ❑ Struck by object ❑ Bite/sting ❑ Training ❑ Vehicle accident, with injury ❑ Vehicle accident, no injury ❑ Cut, puncture, scrape ❑ Other

Body Part Injured (e.g., right wrist, left knee, etc.):	**How Injury Occurred** (struck by…, fell from…, etc.):

Was safety equipment provided? ❑ No ❑ Yes ❑ DNA	Was safety equipment utilized? ❑ No ❑ Yes ❑ DNA	Equipment/materials Employee was using when incident occurred:

Did Employee leave shift to go home? ❑ No ❑ Yes	Unable to work for at least one full day? ❑ No ❑ Yes	Date last worked:	Date returned to work:	Still off work? ❑ No ❑ Yes

Were other Employees injured? ❑ No ❑ Yes If yes, name(s):	Were there witnesses to the incident? ❑ No ❑ Yes If yes, name(s):

Describe any <u>previous</u> conditions/injuries to body part currently injured:

Employee Statement of Incident. This section should be filled out by the Employee and include as much detail as possible, such as activity being performed, objects carried, equipment used, hazardous conditions, etc. Attach additional sheets if necessary:

Recommendation on how to prevent this accident from recurring:

Please check one:

❑ I understand that I **<u>am not</u>** filing a Workers' Compensation claim at this time. I choose not to complete the Form DWC-1, "Employee's Claim for Workers' Compensation Benefits" at this time. If I am in need of medical treatment in the future related to this incident, I will immediately inform my Supervisor and complete the Form DWC-1.

❑ I understand that I **<u>am</u>** filing a Workers' Compensation claim at this time. I am also aware that I must also immediately inform my Supervisor and complete the Form DWC-1.

Employee Acknowledgement: The above information is true and correct to the best of my knowledge.

Employee's Signature:	Date:

SUPERVISOR'S PORTION

Medical Treatment: ❑ Employee requires/requests medical treatment from a physician.
❑ Employee declined medical treatment or only received minor First Aid care. (Please complete page 2)

Do you agree with the Employee Statement of Incident?	❑ No	❑ Yes
Could the injury have been prevented?	❑ No	❑ Yes
If yes, has corrective action been taken or Employee been counseled on prevention of further occurrence?	❑ No	❑ Yes
Was employee trained in the appropriate use of Personal Protective Equipment/Proper safety procedures?	❑ No	❑ Yes
Was employee cautioned for failure to use Personal Protective Equipment/Proper safety procedures?	❑ No	❑ Yes
Had any safety hazards that contributed to this incident been previously reported?	❑ No	❑ Yes
Did employee promptly report the injury/illness?	❑ No	❑ Yes

Please indicate what contributed to the injury or illness (check all that apply):

❑ Improper instruction	❑ Unsafe arrangement or process	❑ Lack of training or skill	❑ Unsafe position or posture
❑ Poor ventilation	❑ Operating without authority	❑ Improper dress	❑ Distraction/Horseplay
❑ Improper maintenance	❑ Physical or mental impairment	❑ Unsafe/defective equipment	❑ Unguarded hazard
❑ Improper use of equipment	❑ Improper lifting technique	❑ Failure to wear/improper use of protective equipment	
❑ Inoperative safety device	❑ Poor housekeeping	❑ Other _____	

Supervisor comments regarding incident (***<u>Required</u>***: Comments are forwarded to the City-Wide Safety Committee for review):

Supervisor Name:	Title:	Telephone:

Signature:	Date:

CITY OF CHICO
DECLINATION OF MEDICAL TREATMENT

This form should be completed ONLY if the Employee DECLINES medical treatment. If the Employee visits their pre-designated physician or the City's designated medical facility the "Employee's Claim for Workers' Compensation Benefits" (Form DWC-1) must also be completed.

EMPLOYEE: Check all that apply.

❑ In my opinion, I am not in need of any medical treatment at this time

OR

In my opinion, I have received sufficient First Aid care in the form of:

❑ Application of antiseptics
❑ Treatment of first-degree burn(s)
❑ Application of bandage(s)
❑ Use of elastic bandage(s)
❑ Removal of foreign bodies not embedded in eye (only irrigation required)
❑ Removal of foreign bodies from wound (uncomplicated procedure, for example, using tweezers)
❑ Use of nonprescription medications
❑ Application of hot or cold compress(es)
❑ Application of ointments to abrasions to prevent drying or cracking

I am fully capable of performing my Usual and Customary position. At this time, I decline medical care. If I need medical care related to this incident in the future, I will notify my Supervisor immediately and complete the Form DWC-1.

Employee Name: _____ Job Title: _____

Employee Signature: _____ Date: _____

SUPERVISOR:

Supervisor Name: _____ Job Title: _____

Supervisor Signature: _____ Date: _____

Note: California Labor Code Section 5401(a) defines a First Aid injury as "any one-time treatment, and any follow-up visit for the purpose of observation of minor scratches, cuts, burns, splinters, or other minor industrial injury, which does not ordinarily require medical care" and states that any injury that "results in lost time beyond the employee's work shift at the time of injury or which results in medical treatment beyond first aid" must be filed as a claim. All of the treatments detailed above fall under the First Aid category; therefore, unless further treatment is necessary, a workers' compensation claim does not need to be filed.