SUPERVISOR INCIDENT CHECK LIST

DECLINATION OF TREATMENT - NOT SEEKING TREATMENT

DO NOT PROVIDE A DWC-1 UNLESS EMPLOYEE IS SEEKING TREATMENT

FOLLOW DEPARTMENT POLICY: report the injury to our intake line at **(888) 826-7835**
Complete the Immediate Supervisor's Report of Employee Injury (Safety Form 674). Send the original to Safety Division, a copy to the Workers' Compensation Division, and retain a copy for your records.
Complete Section B of the Workers' Compensation Acknowledgment Form (WC Form 35)
Have employee complete the Declination of Treatment Statement (WC Form 5a)

- ***If employee later requests treatment, provide employee with the DWC-1 within 24 hours along with the information listed above.***

Employee Name:_____ **Date of Injury/Illness:** _____

RIVCO 1HR workers' compensation

WORKERS' COMPENSATION ACKNOWLEDGEMENT FORM

DECLINATION OF MEDICAL TREATMENT

I notified my supervisor or employer of an injury or illness which occurred on _____ and have been advised that I may seek medical treatment. I do not wish to seek medical attention at this time and therefore was not provided with a Workers' Compensation Claim Form (DWC-1) and have completed *Declination Statement (form WC 5a)*

Initial here: _____

If, I elect to seek treatment for said injury of illness, I will advise my supervisor or employer immediately and will be offered a DWC-1 to complete.

Initial here: _____

Employee Signature:_____ Date: _____

Print Name:_____ SS#: _____

Department:_____ Employee Number: _____

Location: _____

Supervisor:_____ Date: _____

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IMMEDIATE SUPERVISOR'S REPORT OF EMPLOYEE INJURY
ACCIDENT INVESTIGATION

DECLINATION OF TREATMENT STATEMENT

I,_____, notified my supervisor or employer of the injury or illness described below and have been advised that I may seek medical treatment. At this time, I am reporting the incident for reporting purposes only and declining medical attention and or treatment at this time. Therefore, I was not provided with a Workers' Compensation Claim Form (DWC-1) (see California Labor *Code 5401, below*).

Initial here: _____

I HAVE DECLINED THE OFFER OF MEDICAL TREATMENT FOR THE INJURY AS FOLLOWS:

Date of Injury or Illness:_____Time of Injury: _____

How Did the Incident Occur: _____

_____

Part of Body Affected: _____ Date D

Reason for Declination: _____

_____

I UNDERSTAND If I elect to seek medical treatment without advising or obtaining authorization from my supervisor or employer I may be responsible for the total cost of said treatment and not paid for any lost time from work due to this injury.

Initial here: _____

If I elect to seek medical attention for the injury or illness, as described below, in the future, I will advise my supervisor or employer immediately and will be referred for treatment and be provided with a Workers' Compensation Claim Form (DWC-1) within 24 hours.

Initial here: _____

Employee Signature: _____ Date: _____

Employee Print Name: _____ SS#: _____

Department: _____ Employee Number: _____

Location: _____

Supervisor Signature: _____ Date: _____

Supervisor Print Name: _____

In the event the employee above elects to seek medical treatment for the above injury, the employee will be provided with a DWC-1 to complete and referred for treatment within 24 hours of the employee's request.
Supervisor initial here: _____

SUPERVISOR: Must also complete the Immediate Supervisor's Report of Injury (Safety Form 674), complete Section B of the Workers' Compensation Acknowledgment Form (WC Form 35) and send copies to the Workers' Compensation Division. Report the incident to the injury intake line at **(888) 826-7835**, **if required by department.**

PRINT

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IMMEDIATE SUPERVISOR'S REPORT OF EMPLOYEE INJURY
ACCIDENT INVESTIGATION

Injured Employee Information

Department:		Location Address:					
Injured Employee:		Job Title:		Employee #:		☐ M	☐ F
D.O.B.:		Date of Injury / Incident:		Time of Incident:		☐ am	☐ pm
Employee Work phone:		Work Status: ☐ Full Time	☐ Part Time	☐ Temporary…	☐ Intern	☐ Volunteer	
Date Reported:		Reported to:		Work Phone:			

Injury / Incident: (Please describe the injury/incident in detail below)

(Check all that apply) ☐ Injury ☐ Illness ☐ Near miss ☐ Treated on-site ☐ Urgent Care ☐ Hospitalized

Name Witnesses:		Work Phone:		Emp. ☐ Yes ☐ No
Name Witnesses:		Work Phone:		Emp. ☐ Yes ☐ No

Injured Body Part / Type of Injury

√	Body Part	R	L	√	Body Part	R	L
☐	Head				Torso		
☐	Face				Upper Back		
☐	Neck				Lowers Back		
☐	Eyes	☐	☐		Hips	☐	☐
☐	Shoulders	☐	☐		Thighs	☐	☐
☐	Upper Arms	☐	☐		Knees	☐	☐
☐	Elbows	☐	☐		Lower Legs	☐	☐
☐	Forearms	☐	☐		Ankles	☐	☐
☐	Wrists	☐	☐		Foot/Feet	☐	☐
☐	Hands	☐	☐		Toes	☐	☐
☐	Fingers	☐	☐		Other:	☐	☐

Type of injury: (Check most serious one)	
☐ Sprain	☐ Rash
☐ Strain	☐ Overexertion
☐ Puncture	☐ Dislocation
☐ Crushed	☐ Fracture
☐ Contusion	☐ Amputation
☐ Abrasion	☐ Whiplash
☐ Burn	☐ Other:

Type specific body part →

What was employee doing prior to the incident? What equipment, tools or apparatus were being used?

What personal protective equipment was used (if any)?	

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IMMEDIATE SUPERVISOR'S REPORT OF EMPLOYEE INJURY
ACCIDENT INVESTIGATION

Nature of injury: (Check most serious one)

- ☐ Struck by
- ☐ Struck against
- ☐ Caught in / under / between
- ☐ Fall, same level
- ☐ Fall, different level
- ☐ Contact with chemical
- ☐ Contact with hot or cold surface
- ☐ Repetitive motion
- ☐ Foreign body in eye or skin
- ☐ Electrical shock
- ☐ Object being lifted or handled
- ☐ Contact with chemical
- ☐ Contact with hot or cold surface
- ☐ Inhalation, ingestion or absorption
- ☐ Vehicle accident
- ☐ Other:

Unsafe workplace conditions: (Check all that apply)

- ☐ Inadequate / unguarded hazard
- ☐ Uneven or obstructed walking surface
- ☐ Safety device is defective
- ☐ Leaving defective tool or equipment in service
- ☐ Workstation / area layout is hazardous
- ☐ Inadequate lighting
- ☐ Inadequate ventilation
- ☐ Required personal protective equipment not provided
- ☐ Lack of appropriate equipment / tools
- ☐ Improper clothing worn
- ☐ No training or insufficient training
- ☐ Other:

Unsafe acts by people: (Check all that apply)

- ☐ Operating without permission
- ☐ Operating at unsafe speed
- ☐ Servicing equipment that has power to it
- ☐ Making a safety device inoperative
- ☐ Using defective tool or equipment
- ☐ Using tool / equipment in an unapproved way
- ☐ Improper lifting or material handling technique
- ☐ Taking an awkward position or posture
- ☐ Distraction, teasing, horseplay, inattention
- ☐ Failure to wear / use required personal protective equipment
- ☐ Failure to use the appropriate equipment / tools for job
- ☐ Other:

Why did the unsafe conditions exist?

Why did the unsafe acts occur?

Why did the unsafe condition(s) exist?	☐ Y ☐ N	Why did the unsafe act(s) occur?	☐ Y ☐ N

How can future injuries / incidents be prevented?

Corrective Action Taken

Attachments: ☐ Yes ☐ No Totals to the right →	Written witness statements:	#	Photographs:	#	Maps / drawings:	#

Employee Signature _____ Date _____

Signature of Dept. Head _____ Date _____

Supervisor Signature _____ Date _____

Safety Coordinator _____ Date _____