UCLA

Electronic First Report V2

NEW CLAIM CREATION

August 2015

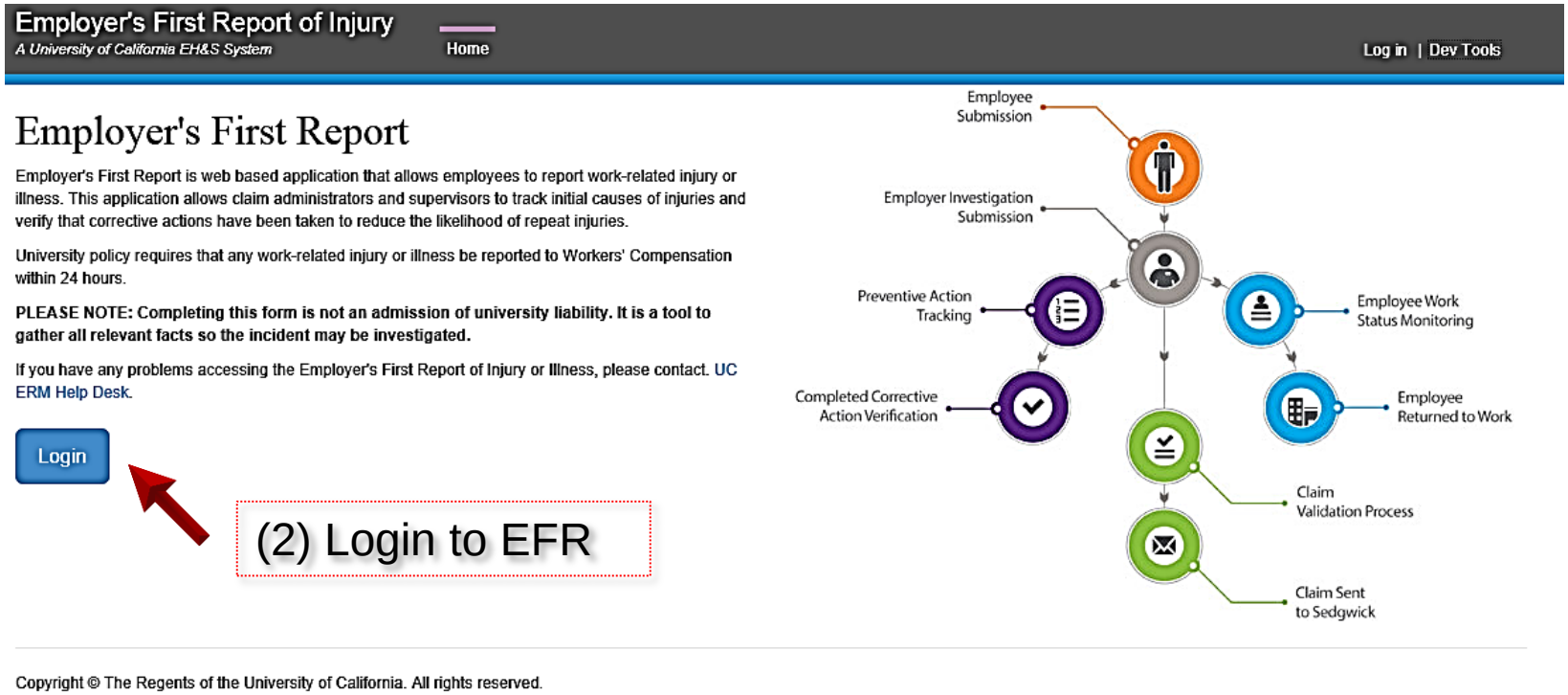
Optimizing strategies.

UCLA IRM

Insurance & Risk Management

New Claim Creation

(1) Navigate to: https://ehs.ucop.edu/efr/



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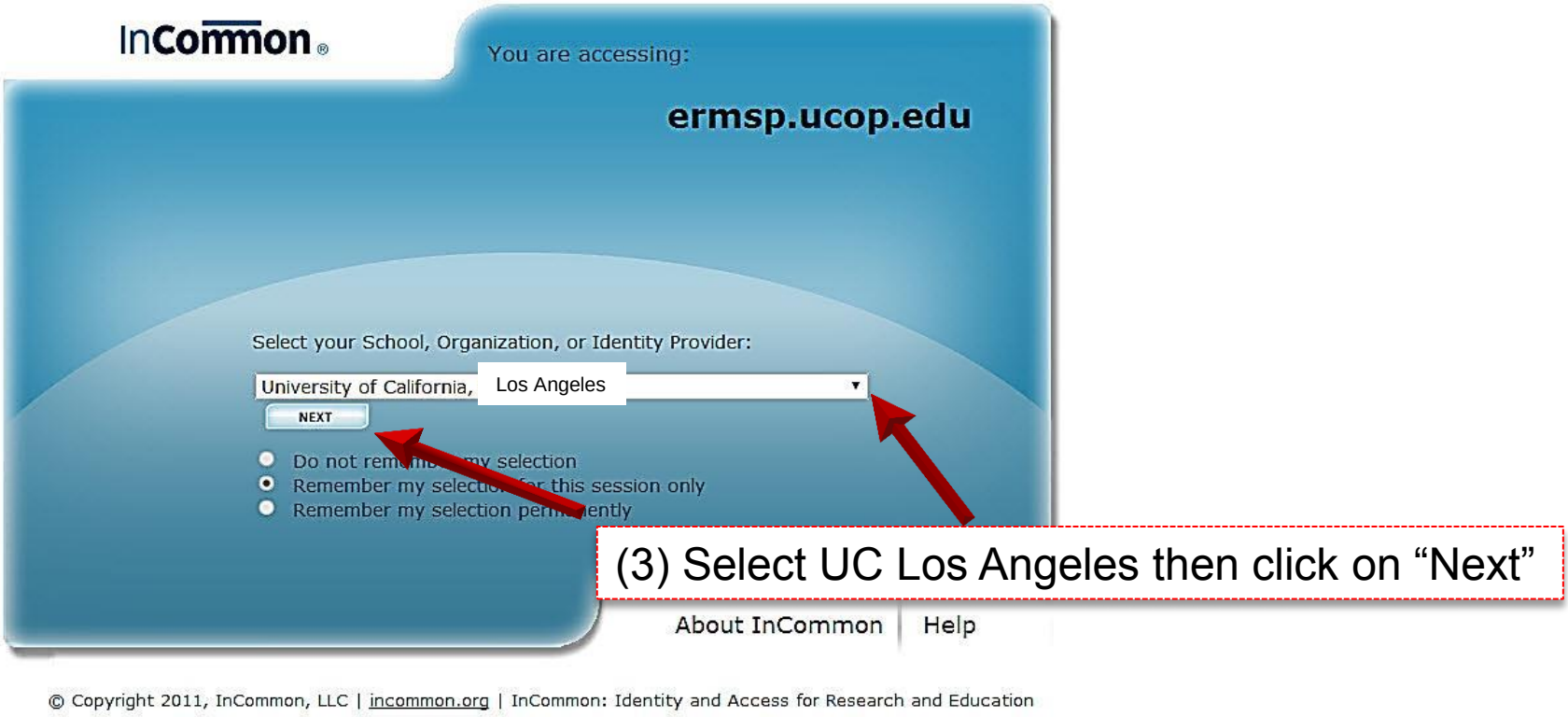
New Claim Creation



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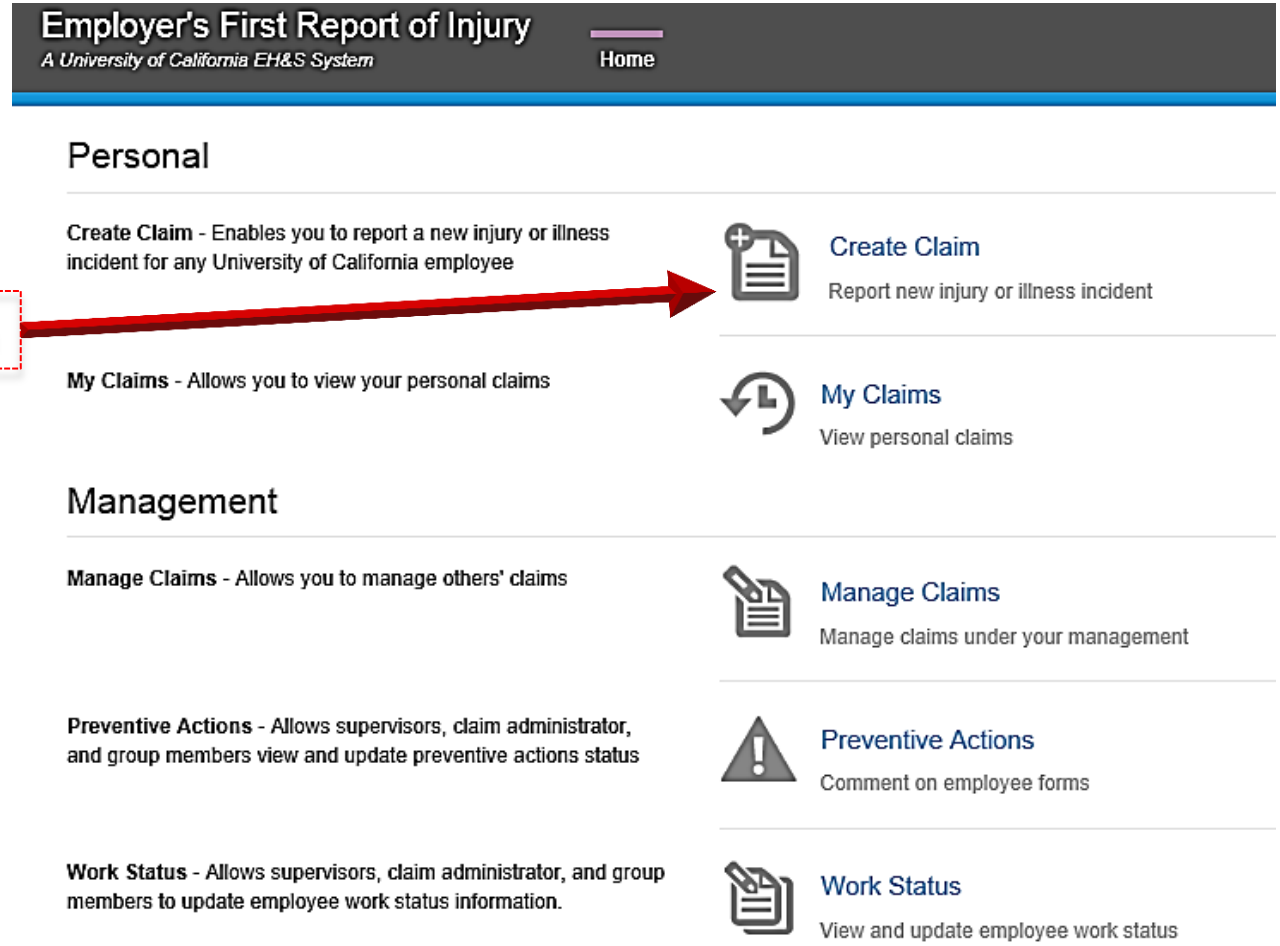
New Claim Creation

(4) Create New Claim



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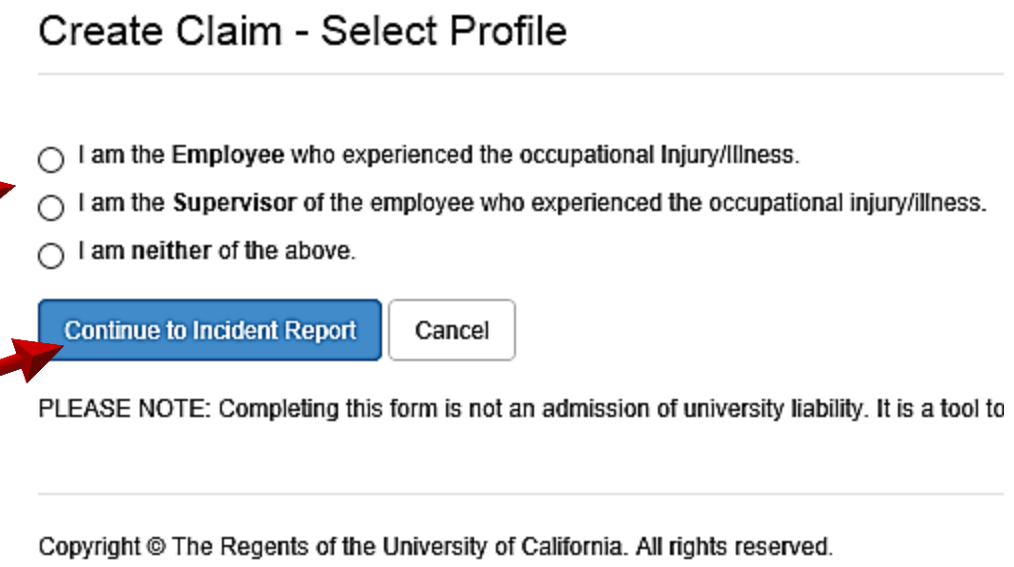
New Claim Creation



(5) Identify who is creating the new claim.

(6) Continue to new claim

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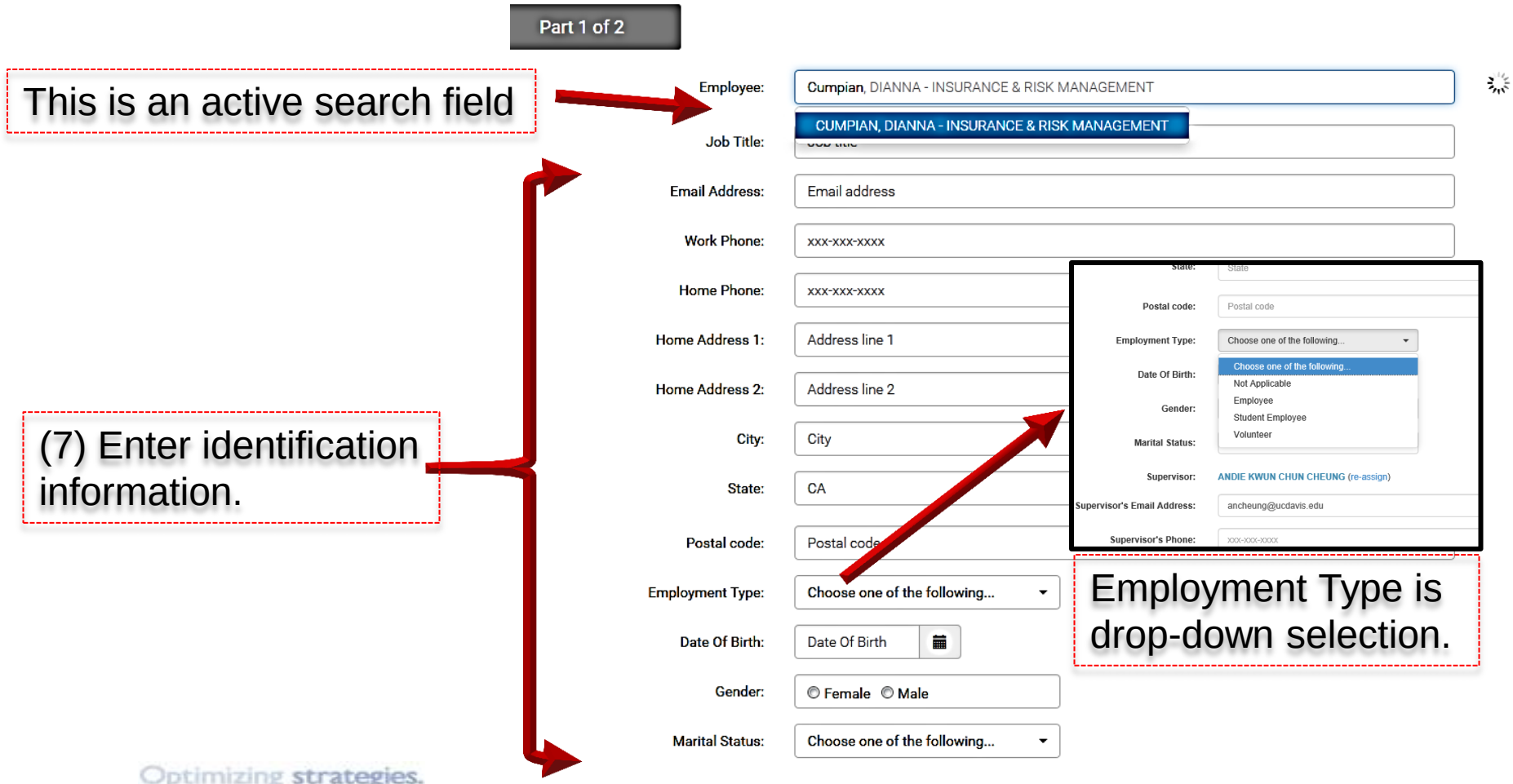
New Claim Creation



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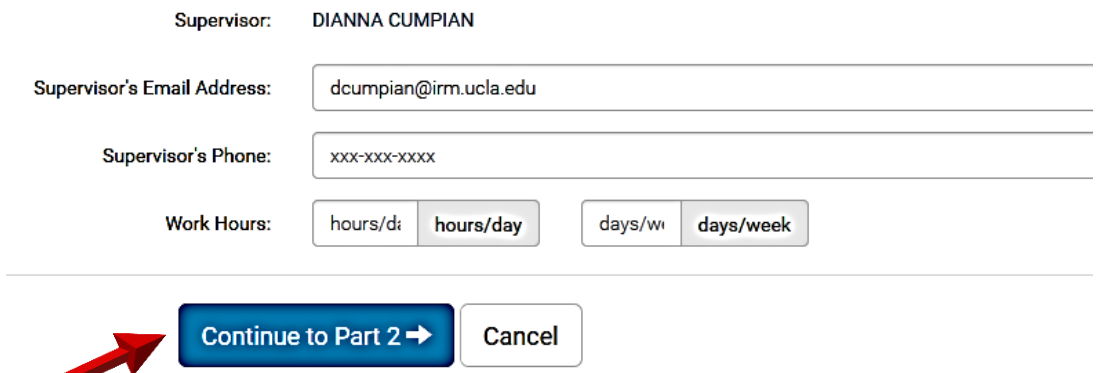
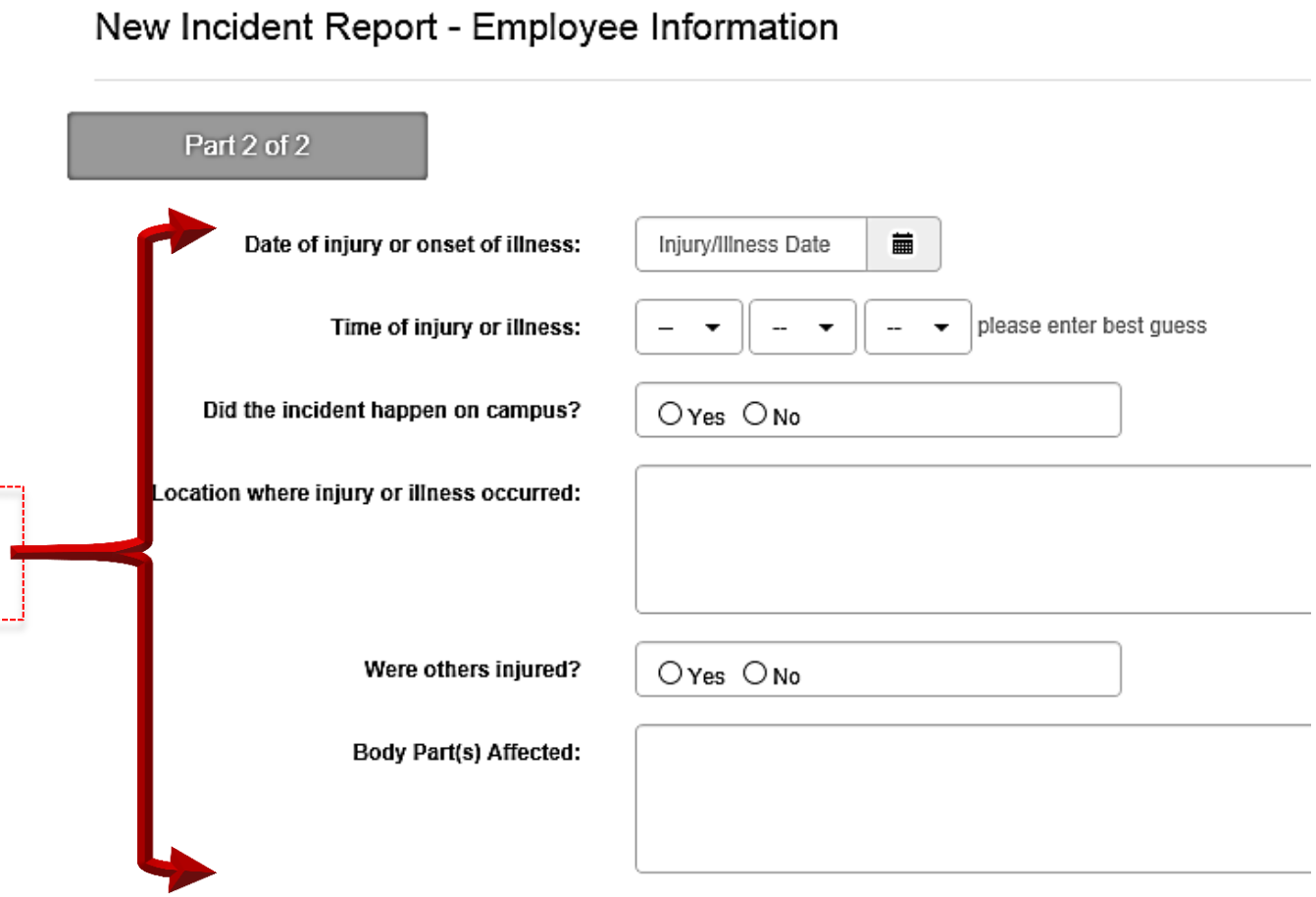
New Claim Creation



(8) Finish all entry information then continue to Part 2.

New Claim Creation



(9) Enter incident date and incident specifics.

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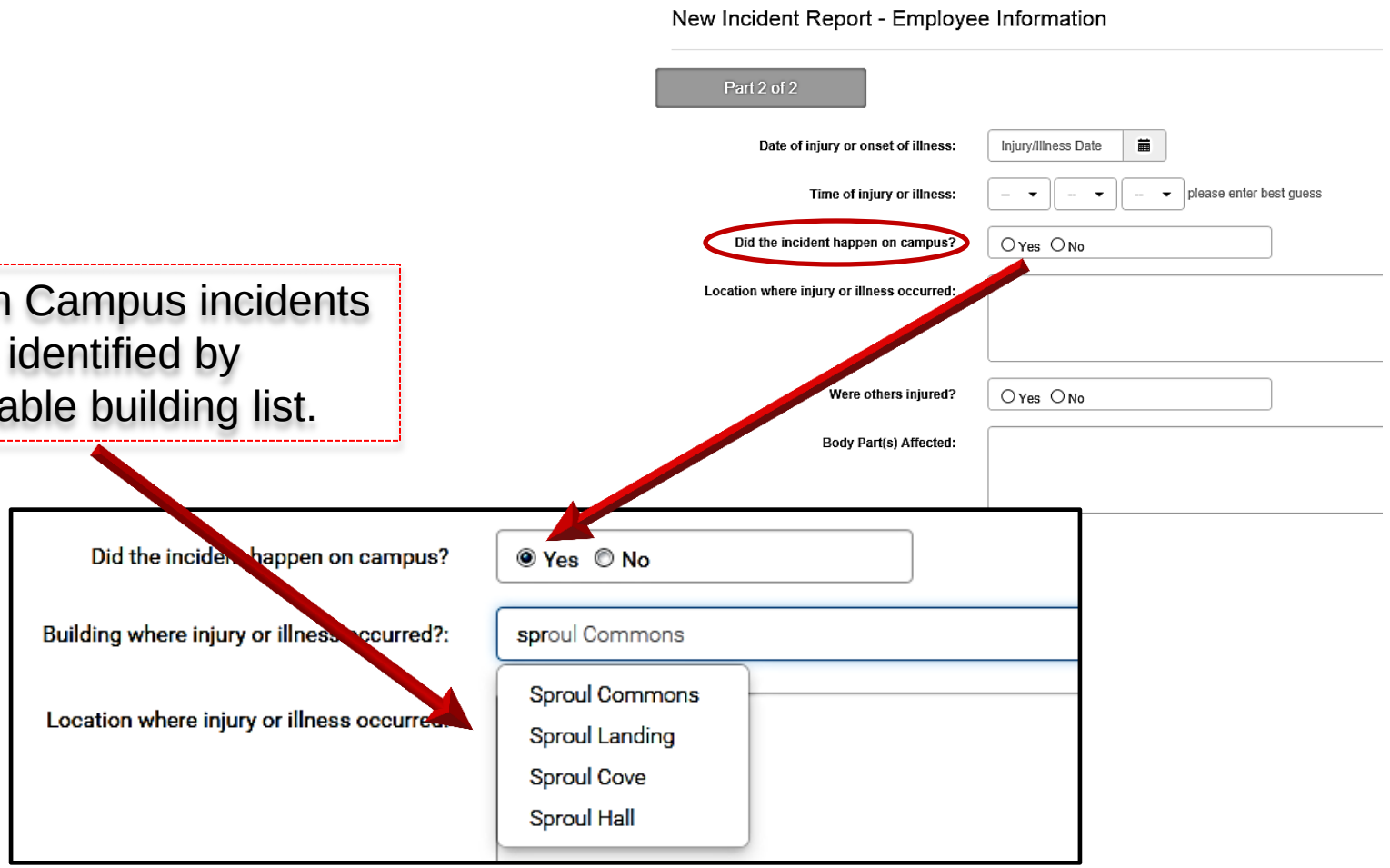
New Claim Creation

(10) On Campus incidents can be identified by searchable building list.



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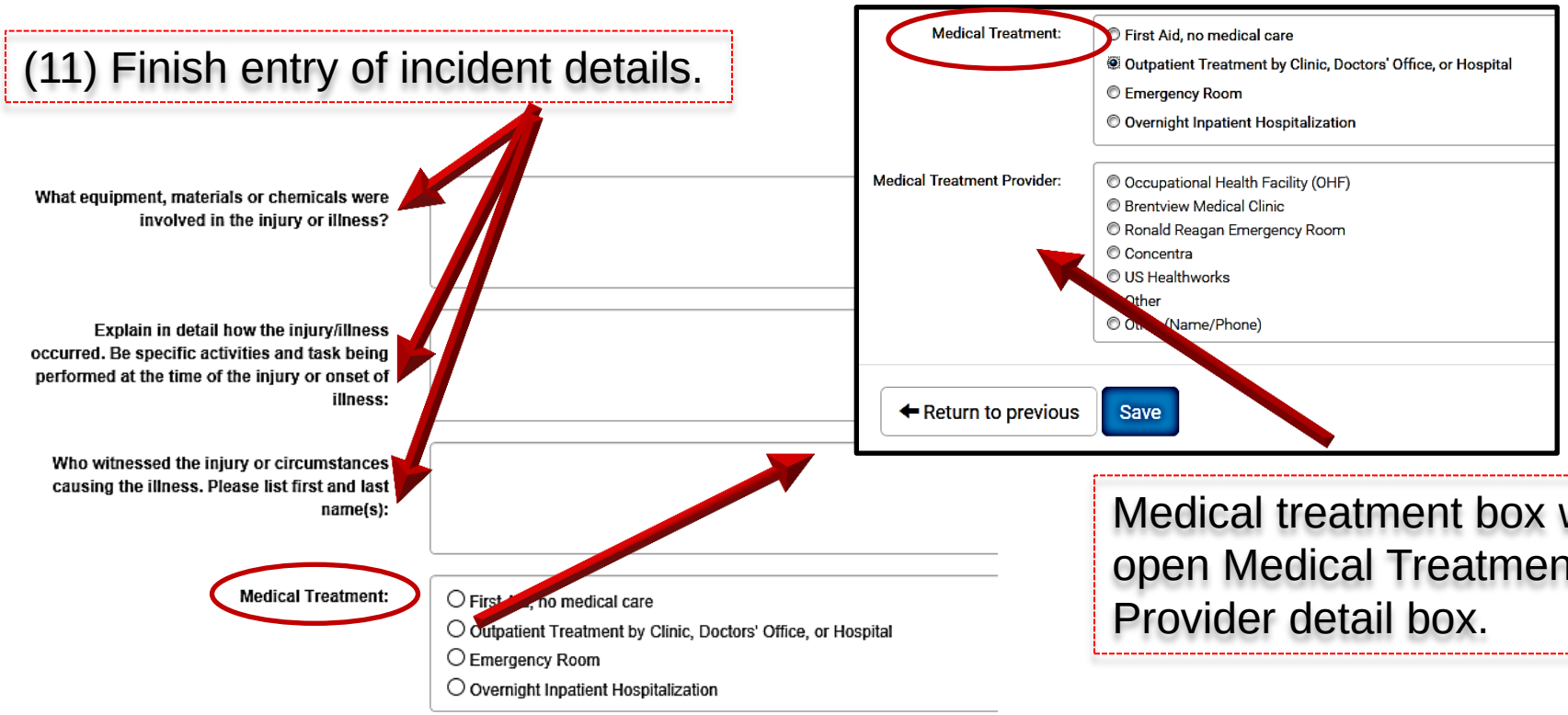
New Claim Creation

(11) Finish entry of incident details.



Medical treatment box will open Medical Treatment Provider detail box.

(12) Finish New Claim entry.

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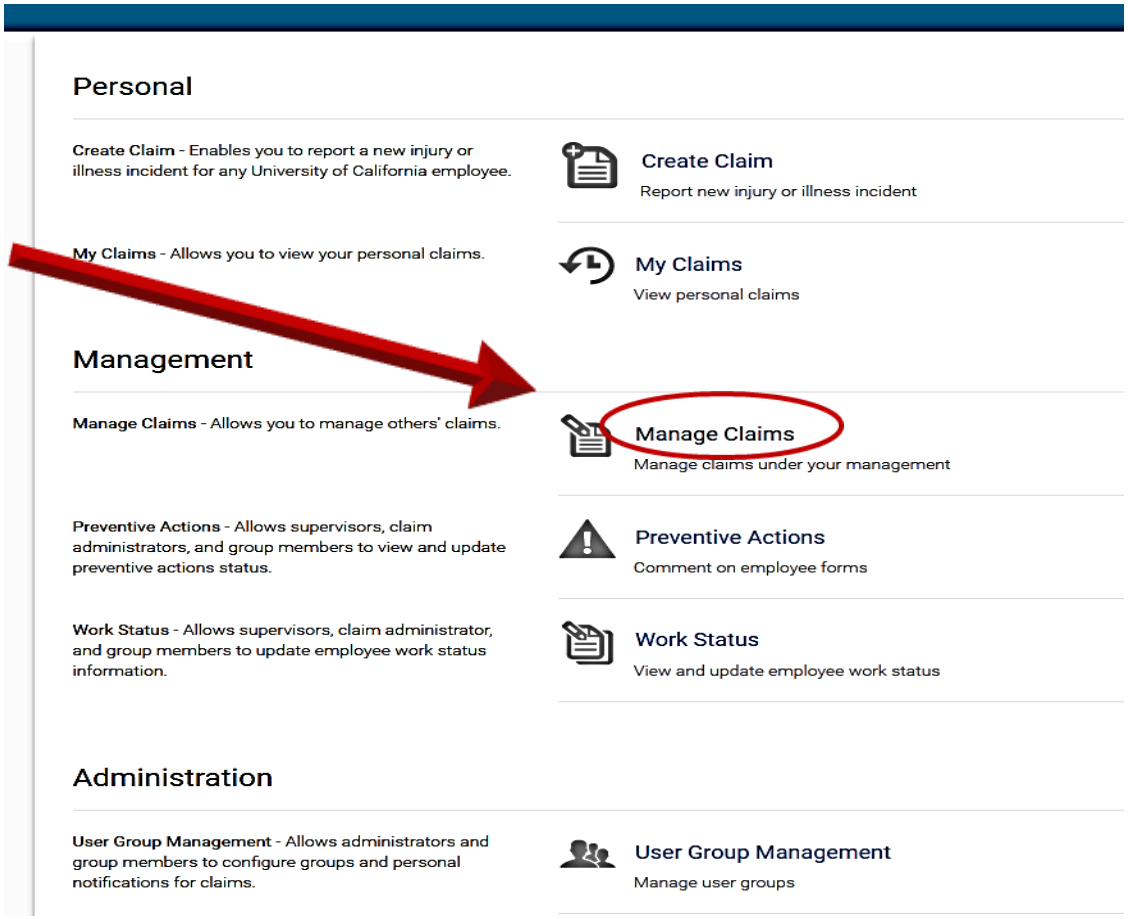
New Claim Creation

(13) Go To Manage Claims



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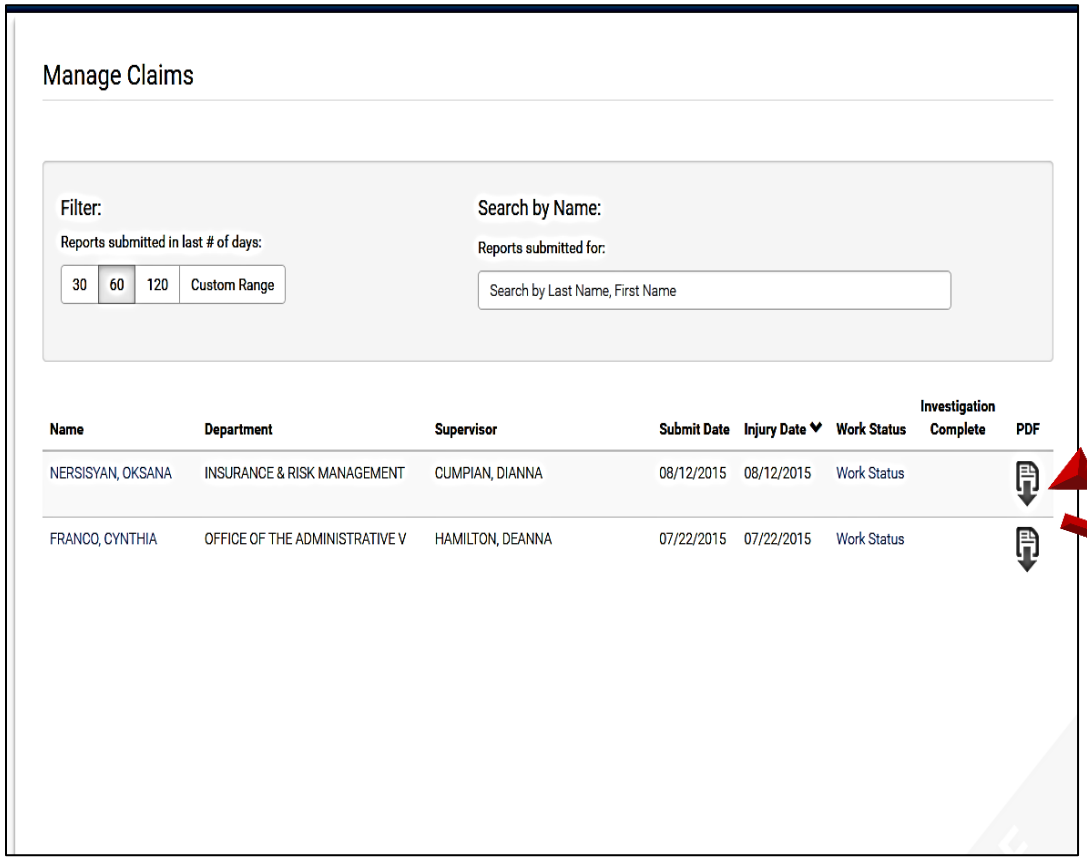
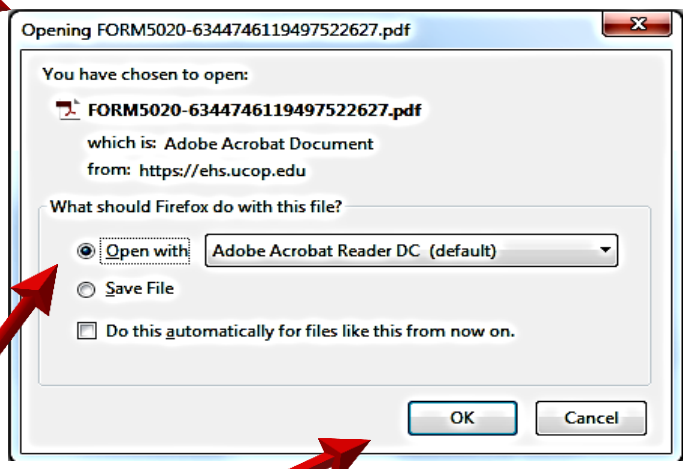
New Claim Creation



(14) Print PDF of Claim Report

Click PDF icon



Select ‘Open with’ then click ok

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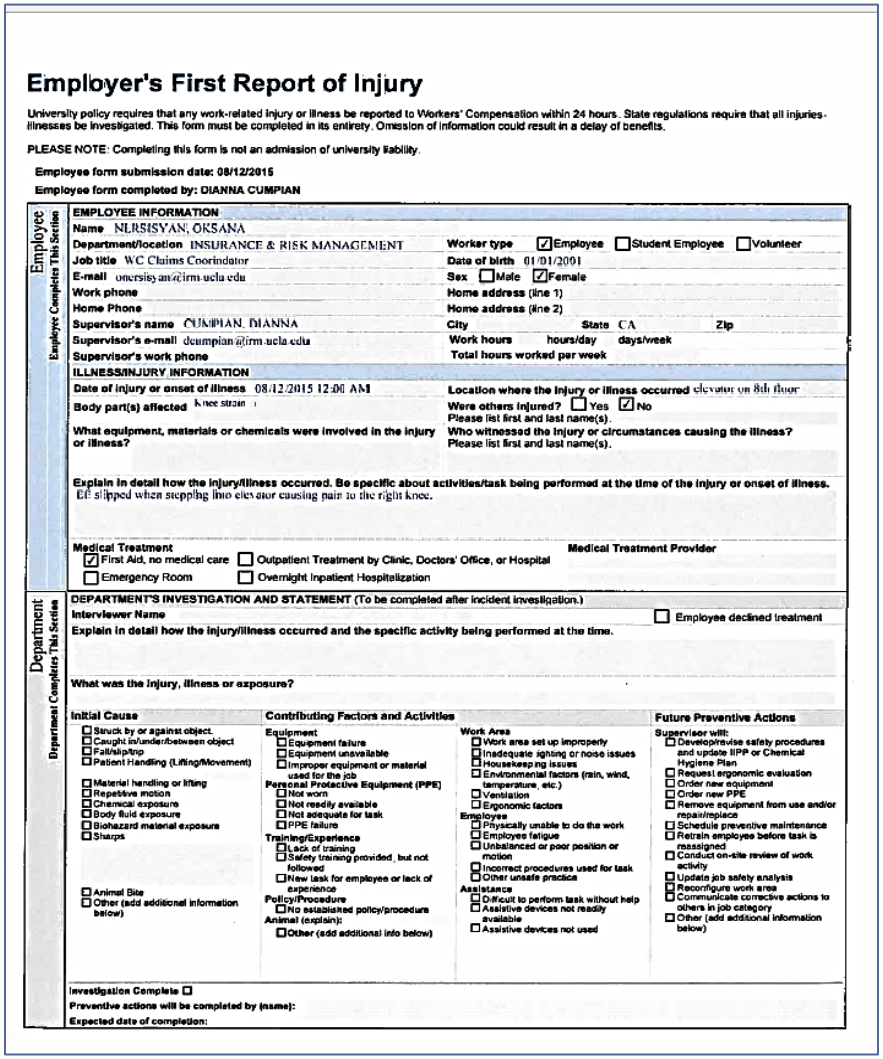
New Claim Creation

Claim report will open in 'Adobe Acrobat' program. Use "Print" feature in this program to print this report then immediately close the report on your computer.



Employer's First Report of Injury

University policy requires that any work-related injury or illness be reported to Workers' Compensation within 24 hours. State regulations require that all injuries-illnesses be investigated. This form must be completed in its entirety. Omission of information could result in a delay of benefits.

PLEASE NOTE: Completing this form is not an admission of university liability.

Employee form submission date: 08/12/2015

Employee form completed by: DIANNA CUMPIAN

Employee Completes This Section

EMPLOYEE INFORMATION

Name NERSISYAN, OKSANA

Department/location INSURANCE & RISK MANAGEMENT

Job title WC Claims Coorindator

E-mail onersisyan@irm.ucla.edu

Work phone

Home Phone

Supervisor's name CUMPIAN, DIANNA

Supervisor's e-mail dcumpian@irm.ucla.edu

Supervisor's work phone

Worker type ☑ Employee ☐ Student Employee ☐ Volunteer

Date of birth 01/01/2001

Sex ☐ Male ☑ Female

Home address (line 1)

Home address (line 2)

City State CA Zip

Work hours hours/day days/week

Total hours worked per week

ILLNESS/INJURY INFORMATION

Date of injury or onset of illness 08/12/2015 12:00 AM

Location where the injury or illness occurred elevator on 8th floor

Body part(s) affected knee strain

Were others injured? ☐ Yes ☑ No

Please list first and last name(s).

What equipment, materials or chemicals were involved in the injury or illness?

Who witnessed the injury or circumstances causing the illness? Please list first and last name(s).

Explain in detail how the injury/illness occurred. Be specific about activities/task being performed at the time of the injury or onset of illness.

EE slipped when stepping into elevator causing pain to the right knee.

Medical Treatment

☑ First Aid, no medical care ☐ Outpatient Treatment by Clinic, Doctors' Office, or Hospital

☐ Emergency Room ☐ Overnight Inpatient Hospitalization

Medical Treatment Provider

Department Completes This Section

DEPARTMENT'S INVESTIGATION AND STATEMENT (To be completed after incident investigation.)

Interviewer Name ☐ Employee declined treatment

Explain in detail how the injury/illness occurred and the specific activity being performed at the time.

What was the injury, illness or exposure?

Initial Cause	Contributing Factors and Activities		Future Preventive Actions
☐ Struck by or against object. ☐ Caught in/under/between object ☐ Fall/slip/trip ☐ Patient Handling (Lifting/Movement) ☐ Material handling or lifting ☐ Repetitive motion ☐ Chemical exposure ☐ Body fluid exposure ☐ Biohazard material exposure ☐ Sharps ☐ Animal Bite ☐ Other (add additional information below)	Equipment ☐ Equipment failure ☐ Equipment unavailable ☐ Improper equipment or material used for the job Personal Protective Equipment (PPE) ☐ Not worn ☐ Not readily available ☐ Not adequate for task ☐ PPE failure Training/Experience ☐ Lack of training ☐ Safety training provided, but not followed ☐ New task for employee or lack of experience Policy/Procedure ☐ No established policy/procedure Animal (explain): ☐ Other (add additional info below)	Work Area ☐ Work area set up improperly ☐ Inadequate lighting or noise issues ☐ Housekeeping issues ☐ Environmental factors (rain, wind, temperature, etc.) ☐ Ventilation ☐ Ergonomic factors Employee ☐ Physically unable to do the work ☐ Employee fatigue ☐ Unbalanced or poor position or motion ☐ Incorrect procedures used for task ☐ Other unsafe practice Assistance ☐ Difficult to perform task without help ☐ Assistive devices not readily available ☐ Assistive devices not used	Supervisor will: ☐ Develop/revise safety procedures and update IIPP or Chemical Hygiene Plan ☐ Request ergonomic evaluation ☐ Order new equipment ☐ Order new PPE ☐ Remove equipment from use and/or repair/replace ☐ Schedule preventive maintenance ☐ Retrain employee before task is reassigned ☐ Conduct on-site review of work activity ☐ Update job safety analysis ☐ Reconfigure work area ☐ Communicate corrective actions to others in job category ☐ Other (add additional information below)

Investigation Complete ☐

Preventive actions will be completed by (name):

Expected date of completion:

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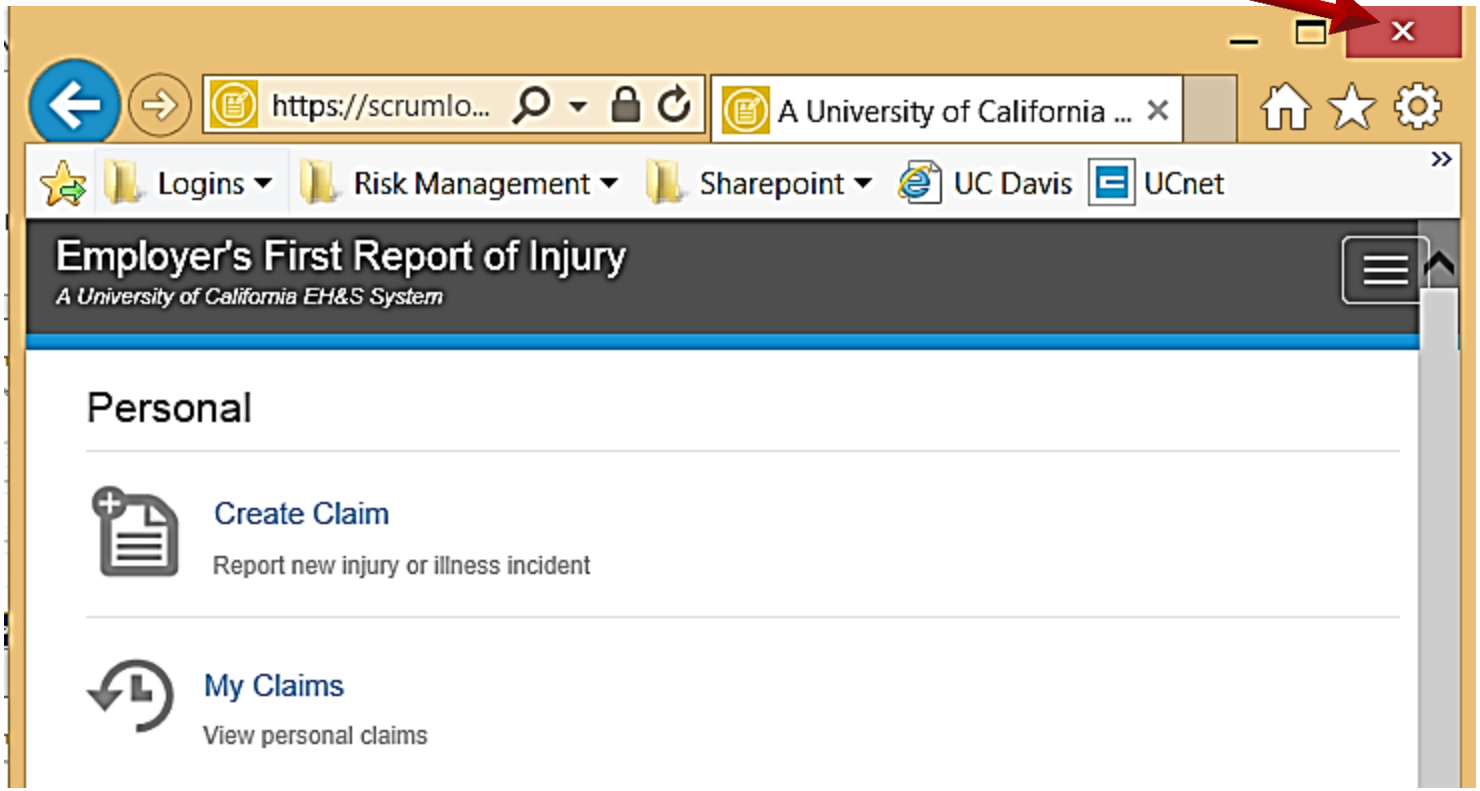
New Claim Creation

(12) Close Browser



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New Claim Creation

EFR System immediately sends an email for each claim to the following:

Employee (if email address provided)
Supervisor
Human Resources (HR) Department
Department of Insurance and Risk Management
Occupational Health Facility (OHF)
Environmental Health & Safety (EHS)

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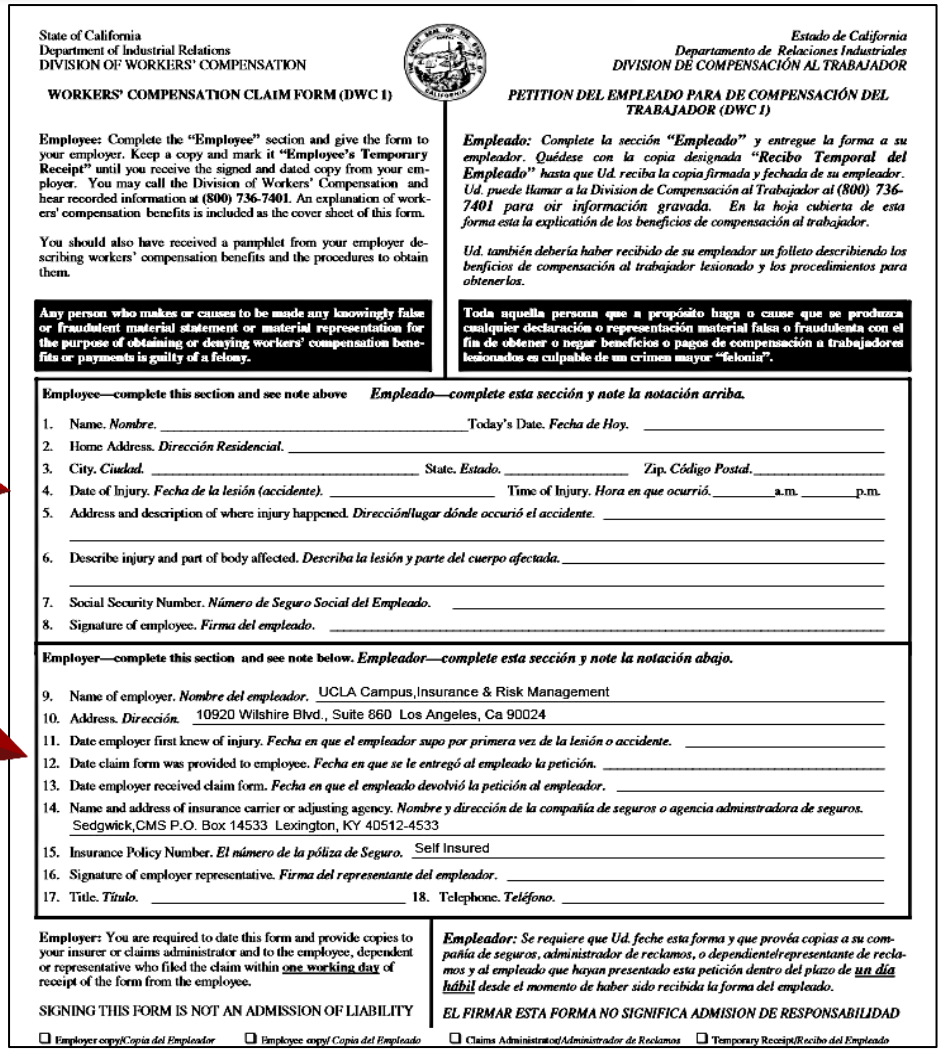
New Claim Creation

(15) Complete Workers' Compensation Claim Form DWC-1

Employee completes 1-8

Supervisor completes 9-17



State of California
Department of Industrial Relations
DIVISION OF WORKERS' COMPENSATION

Estado de California
Departamento de Relaciones Industriales
DIVISION DE COMPENSACIÓN AL TRABAJADOR

WORKERS' COMPENSATION CLAIM FORM (DWC 1)

PETITION DEL EMPLEADO PARA DE COMPENSACIÓN DEL TRABAJADOR (DWC 1)

Employee: Complete the **"Employee"** section and give the form to your employer. Keep a copy and mark it **"Employee's Temporary Receipt"** until you receive the signed and dated copy from your employer. You may call the Division of Workers' Compensation and hear recorded information at **(800) 736-7401**. An explanation of workers' compensation benefits is included as the cover sheet of this form.

You should also have received a pamphlet from your employer describing workers' compensation benefits and the procedures to obtain them.

Empleado: *Complete la sección* ***"Empleado"*** *y entregue la forma a su empleador. Quédese con la copia designada* ***"Recibo Temporal del Empleado"*** *hasta que Ud. reciba la copia firmada y fechada de su empleador. Ud. puede llamar a la División de Compensación al Trabajador al* ***(800) 736-7401*** *para oir información gravada. En la hoja cubierta de esta forma esta la explicatión de los beneficios de compensación al trabajador.*

Ud. también debería haber recibido de su empleador un folleto describiendo los beneficios de compensación al trabajador lesionado y los procedimientos para obtenerlos.

Any person who makes or causes to be made any knowingly false or fraudulent material statement or material representation for the purpose of obtaining or denying workers' compensation benefits or payments is guilty of a felony.

Toda aquella persona que a propósito haga o cause que se produzca cualquier declaración o representación material falsa o fraudulenta con el fin de obtener o negar beneficios o pagos de compensación a trabajadores lesionados es culpable de un crimen mayor "felonia".

Employee—complete this section and see note above ***Empleado—complete esta sección y note la notación arriba.***

1. Name. *Nombre.* _____ Today's Date. *Fecha de Hoy.* _____
2. Home Address. *Dirección Residencial.* _____
3. City. *Ciudad.* _____ State. *Estado.* _____ Zip. *Código Postal.* _____
4. Date of Injury. *Fecha de la lesión (accidente).* _____ Time of Injury. *Hora en que ocurrió.* _____ a.m. _____ p.m.
5. Address and description of where injury happened. *Dirección/lugar dónde occurió el accidente.* _____
6. Describe injury and part of body affected. *Describa la lesión y parte del cuerpo afectada.* _____
7. Social Security Number. *Número de Seguro Social del Empleado.* _____
8. Signature of employee. *Firma del empleado.* _____

Employer—complete this section and see note below. ***Empleador—complete esta sección y note la notación abajo.***

9. Name of employer. *Nombre del empleador.* UCLA Campus,Insurance & Risk Management
10. Address. *Dirección.* 10920 Wilshire Blvd., Suite 860 Los Angeles, Ca 90024
11. Date employer first knew of injury. *Fecha en que el empleador supo por primera vez de la lesión o accidente.* _____
12. Date claim form was provided to employee. *Fecha en que se le entregó al empleado la petición.* _____
13. Date employer received claim form. *Fecha en que el empleado devolvió la petición al empleador.* _____
14. Name and address of insurance carrier or adjusting agency. *Nombre y dirección de la compañía de seguros o agencia adminstradora de seguros.* Sedgwick,CMS P.O. Box 14533 Lexington, KY 40512-4533
15. Insurance Policy Number. *El número de la póliza de Seguro.* Self Insured
16. Signature of employer representative. *Firma del representante del empleador.* _____
17. Title. *Título.* _____ 18. Telephone. *Teléfono.* _____

Employer: You are required to date this form and provide copies to your insurer or claims administrator and to the employee, dependent or representative who filed the claim within **one working day** of receipt of the form from the employee.

Empleador: *Se requiere que Ud. feche esta forma y que provéa copias a su compañía de seguros, administrador de reclamos, o dependiente/representante de reclamos y al empleado que hayan presentado esta petición dentro del plazo de* ***un día hábil*** *desde el momento de haber sido recibida la forma del empleado.*

SIGNING THIS FORM IS NOT AN ADMISSION OF LIABILITY

EL FIRMAR ESTA FORMA NO SIGNIFICA ADMISION DE RESPONSABILIDAD

☐ Employer copy/*Copia del Empleador* ☐ Employee copy/*Copia del Empleado* ☐ Claims Administrator/*Administrador de Reclamos* ☐ Temporary Receipt/*Recibo del Empleado*

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New Claim Creation

Give Employee 2 forms:
Claim Report
Claim Form DWC-1

Send Employee for Medical Care

DONE!

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