

# Electronic First Report V2

NEW CLAIM CREATION

August 2015

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

## Employer's First Report of Injury

A University of California EH&S System

Home

Log in | Dev Tools

## Employer's First Report

Employer's First Report is web based application that allows employees to report work-related injury or illness. This application allows claim administrators and supervisors to track initial causes of injuries and verify that corrective actions have been taken to reduce the likelihood of repeat injuries.

University policy requires that any work-related injury or illness be reported to Workers' Compensation within 24 hours.

**PLEASE NOTE:** Completing this form is not an admission of university liability. It is a tool to gather all relevant facts so the incident may be investigated.

If you have any problems accessing the Employer's First Report of Injury or Illness, please contact. UC ERM Help Desk.

Login

(2) Login to EFR



**InCommon®**

You are accessing:

**ermisp.ucop.edu**

Select your School, Organization, or Identity Provider:

University of California, Los Angeles ▼

**NEXT**

- ☐ Do not remember my selection
- ☒ Remember my selection for this session only
- ☐ Remember my selection permanently

About InCommon | Help

(3) Select UC Los Angeles then click on “Next”

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### Employer's First Report of Injury

A University of California EH&S System

[Home](#)

#### Personal

**Create Claim** - Enables you to report a new injury or illness incident for any University of California employee



[Create Claim](#)

Report new injury or illness incident

**My Claims** - Allows you to view your personal claims



[My Claims](#)

View personal claims

#### Management

**Manage Claims** - Allows you to manage others' claims



[Manage Claims](#)

Manage claims under your management

**Preventive Actions** - Allows supervisors, claim administrator, and group members view and update preventive actions status



[Preventive Actions](#)

Comment on employee forms

**Work Status** - Allows supervisors, claim administrator, and group members to update employee work status information.



[Work Status](#)

View and update employee work status

(4) Create New Claim

### Create Claim - Select Profile

- ☐ I am the **Employee** who experienced the occupational Injury/Illness.
- ☐ I am the **Supervisor** of the employee who experienced the occupational injury/illness.
- ☐ I am **neither** of the above.

[Continue to Incident Report](#)

[Cancel](#)

PLEASE NOTE: Completing this form is not an admission of university liability. It is a tool to

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(5) Identify who is creating the new claim.

(6) Continue to new claim

Part 1 of 2

This is an active search field

(7) Enter identification information.

Employee:

Job Title:

Email Address:

Work Phone:

Home Phone:

Home Address 1:

Home Address 2:

City:

State:

Postal code:

Employment Type:

Date Of Birth:

Gender: ☐ Female ☐ Male

Marital Status:

State:

Postal code:

Employment Type:

Date Of Birth:

Gender: ☐ Not Applicable ☐ Employee ☐ Student Employee ☐ Volunteer

Marital Status:

Supervisor: [ANDIE KWUN CHUN CHEUNG \(re-assign\)](#)

Supervisor's Email Address:

Supervisor's Phone:

Employment Type is drop-down selection.

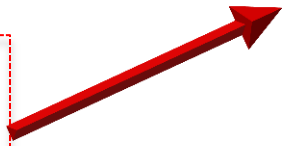
Supervisor: DIANNA CUMPIAN

Supervisor's Email Address:

Supervisor's Phone:

Work Hours:

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



### New Incident Report - Employee Information

Part 2 of 2

Date of injury or onset of illness:

Injury/Illness Date



Time of injury or illness:

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please enter best guess

Did the incident happen on campus?

☐ Yes ☐ No

Location where injury or illness occurred:

Were others injured?

☐ Yes ☐ No

Body Part(s) Affected:

(9) Enter incident date and incident specifics.



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

New Incident Report - Employee Information

Part 2 of 2

Date of injury or onset of illness:

Time of injury or illness:    please enter best guess

**Did the incident happen on campus?** ☐ Yes ☐ No

Location where injury or illness occurred:

Were others injured? ☐ Yes ☐ No

Body Part(s) Affected:

Did the incident happen on campus? ☒ Yes ☐ No

Building where injury or illness occurred?:

Location where injury or illness occurred: 

Sproul Commons  
 Sproul Landing  
 Sproul Cove  
 Sproul Hall

### (11) Finish entry of incident details.

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

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

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

Medical Treatment:

- ☐ First Aid, no medical care
- ☐ Outpatient Treatment by Clinic, Doctors' Office, or Hospital
- ☐ Emergency Room
- ☐ Overnight Inpatient Hospitalization

Medical Treatment:

- ☐ First Aid, no medical care
- ☒ Outpatient Treatment by Clinic, Doctors' Office, or Hospital
- ☐ Emergency Room
- ☐ Overnight Inpatient Hospitalization

Medical Treatment Provider:

- ☐ Occupational Health Facility (OHF)
- ☐ Brentview Medical Clinic
- ☐ Ronald Reagan Emergency Room
- ☐ Concentra
- ☐ US Healthworks
- ☐ Other
- ☐ Other (Name/Phone)

← Return to previous

Save

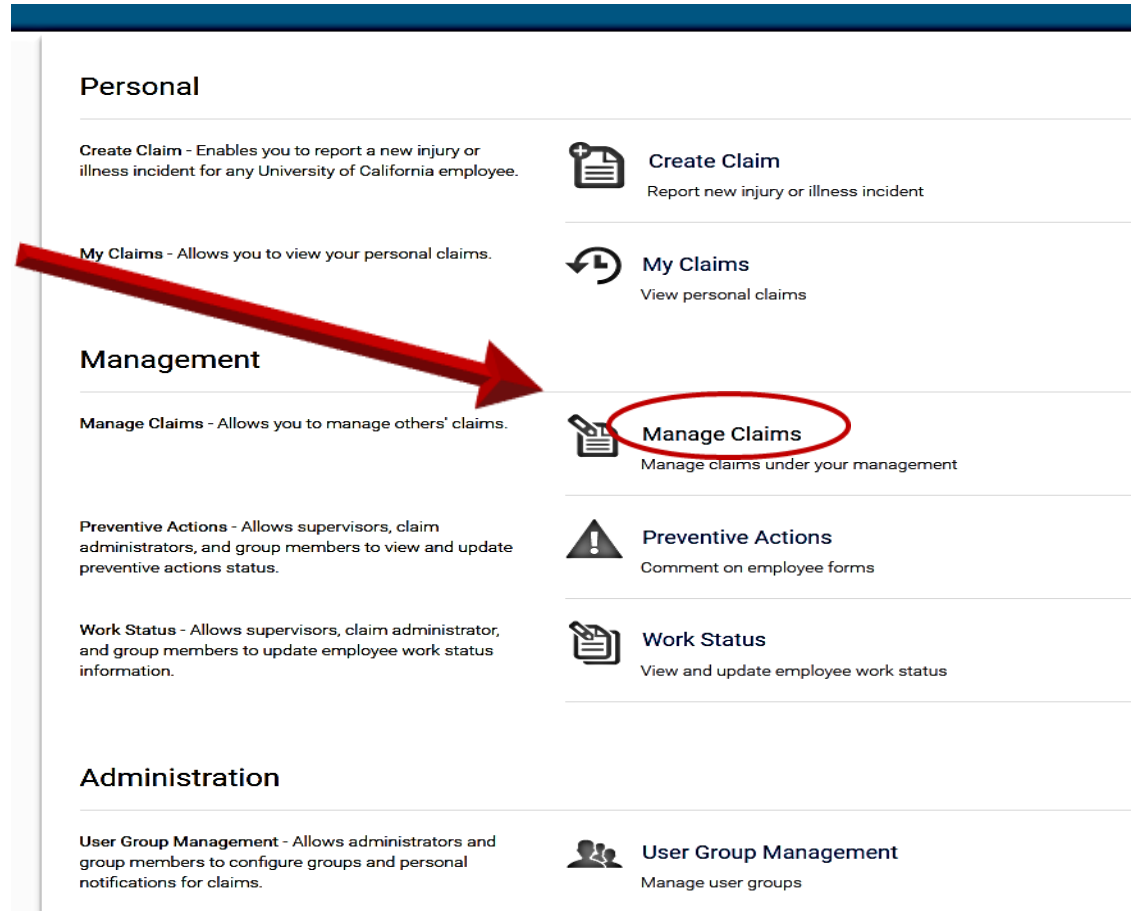
Medical treatment box will open Medical Treatment Provider detail box.

← Return to previous

Save

### (12) Finish New Claim entry.

## (13) Go To Manage Claims



The screenshot displays a web application interface for managing claims. It is organized into three main sections: Personal, Management, and Administration. A red arrow points from the instruction '(13) Go To Manage Claims' to the 'Manage Claims' button, which is circled in red.

Section	Item	Description	Icon
Personal	Create Claim	Report new injury or illness incident	Document with plus icon
	My Claims	View personal claims	Document with circular arrow icon
Management	Manage Claims	Manage claims under your management	Document with pencil icon
	Preventive Actions	Comment on employee forms	Warning triangle icon
	Work Status	View and update employee work status	Document with pencil icon
	User Group Management	Manage user groups	Group of people icon

### Manage Claims

Filter:



Reports submitted in last # of days:

30 60 120 Custom Range

Search by Name:

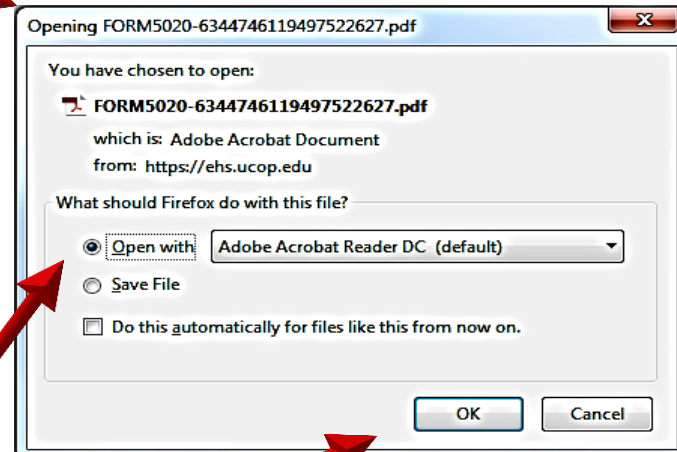
Reports submitted for:

Search by Last Name, First Name

Name	Department	Supervisor	Submit Date	Injury Date ▼	Work Status	Investigation Complete	PDF
NERSISYAN, OKSANA	INSURANCE & RISK MANAGEMENT	CUMPIAN, DIANNA	08/12/2015	08/12/2015	Work Status		
FRANCO, CYNTHIA	OFFICE OF THE ADMINISTRATIVE V	HAMILTON, DEANNA	07/22/2015	07/22/2015	Work Status		

(14) Print PDF of Claim Report

Click PDF icon



Select 'Open with' then click ok

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.

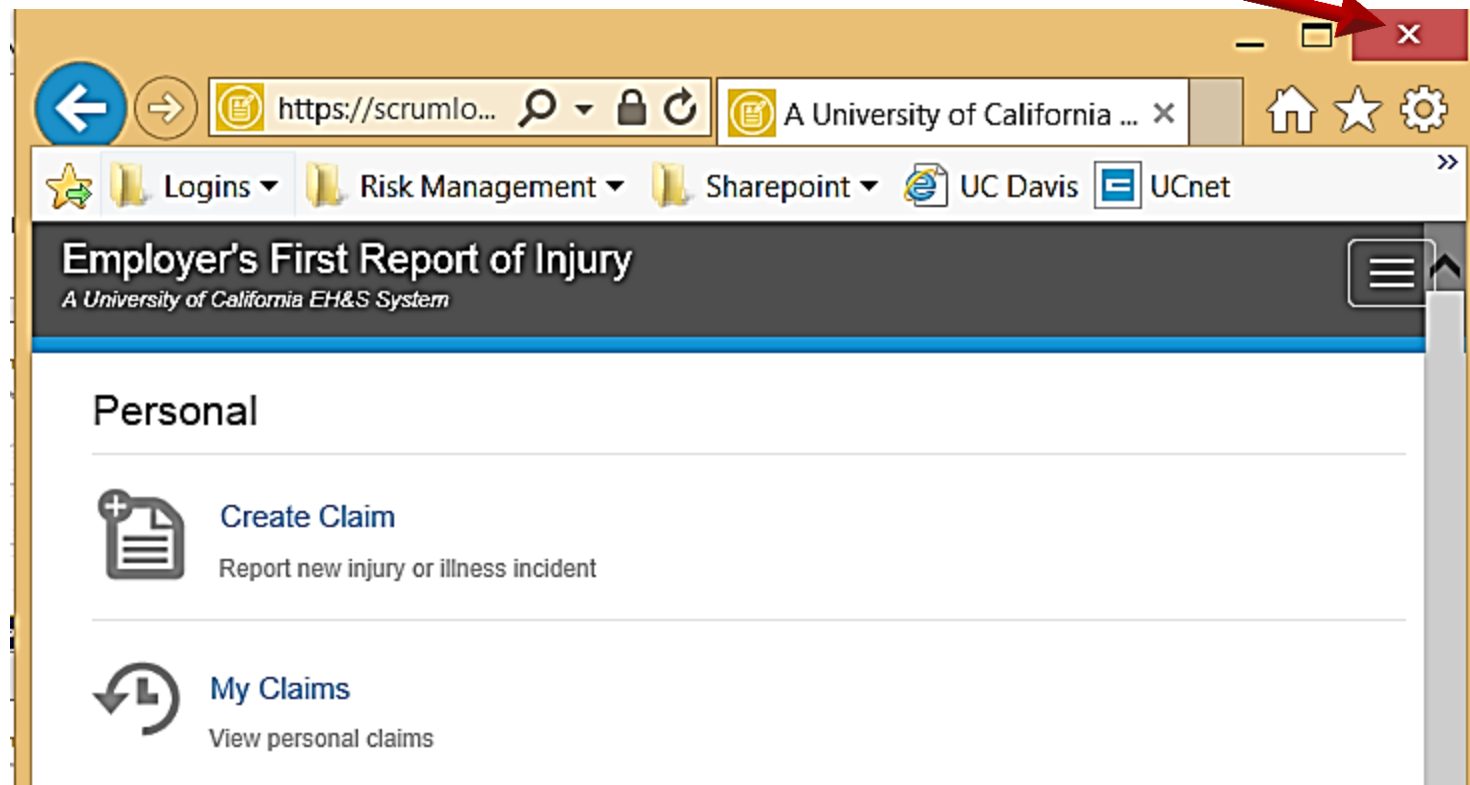
Employee form submission date: 08/12/2015

Employee form completed by: DIANNA CUMPIAN

Employee Information			
Name	NURSISYAN, OKSANA		
Department/Location	INSURANCE & RISK MANAGEMENT		
Job title	WC Claims Coordinator		
E-mail	uncsrisy an@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	<input checked="" type="checkbox"/> Employee <input type="checkbox"/> Student Employee <input type="checkbox"/> Volunteer		
Date of birth	01/01/2001		
Sex	<input type="checkbox"/> Male <input checked="" type="checkbox"/> Female		
Home address (line 1)			
Home address (line 2)			
City	State	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		
Body part(s) affected	Knee, Stomach		
Location where the injury or illness occurred	elevator on 8th floor		
Were others injured?	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
Who witnessed the injury or circumstances causing the illness?	Please list first and last name(s).		
What equipment, materials or chemicals were involved in the injury or illness?			
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		Medical Treatment Provider	
<input checked="" type="checkbox"/> First Aid, no medical care <input type="checkbox"/> Outpatient Treatment by Clinic, Doctors' Office, or Hospital			
<input type="checkbox"/> Emergency Room <input type="checkbox"/> Overnight Inpatient Hospitalization			
DEPARTMENT'S INVESTIGATION AND STATEMENT (To be completed after incident investigation.)			
Interviewer Name			<input type="checkbox"/> 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
<input type="checkbox"/> Struck by or against object <input type="checkbox"/> Caught in/between object <input type="checkbox"/> Falls/slipping <input type="checkbox"/> Patient Handling (Lifting/Movement) <input type="checkbox"/> Material handling or lifting <input type="checkbox"/> Repetitive motion <input type="checkbox"/> Chemical exposure <input type="checkbox"/> Body fluid exposure <input type="checkbox"/> Biohazard material exposure <input type="checkbox"/> Sharps <input type="checkbox"/> Animal Bite <input type="checkbox"/> Other (add additional information below)	<input type="checkbox"/> Equipment <input type="checkbox"/> Equipment failure <input type="checkbox"/> Equipment unavailable <input type="checkbox"/> Improper equipment or material used for the job <input type="checkbox"/> Personal Protective Equipment (PPE) <input type="checkbox"/> Not worn <input type="checkbox"/> Not readily available <input type="checkbox"/> Not adequate for task <input type="checkbox"/> PPE failure <input type="checkbox"/> Training/Experience <input type="checkbox"/> Lack of training <input type="checkbox"/> Safety training provided, but not followed <input type="checkbox"/> New task for employee or lack of experience <input type="checkbox"/> Policy/procedure <input type="checkbox"/> No established policy/procedure <input type="checkbox"/> Animal (explain): <input type="checkbox"/> Other (add additional info below)		<input type="checkbox"/> Work Area <input type="checkbox"/> Work area set up improperly <input type="checkbox"/> Inadequate lighting or noise issues <input type="checkbox"/> Housekeeping issues <input type="checkbox"/> Environmental factors (rain, wind, temperature, etc.) <input type="checkbox"/> Ventilation <input type="checkbox"/> Ergonomic factors <input type="checkbox"/> Employee <input type="checkbox"/> Physically unable to do the work <input type="checkbox"/> Employee fatigue <input type="checkbox"/> Unbalanced or poor position or motion <input type="checkbox"/> Incorrect procedures used for task <input type="checkbox"/> Other unsafe practice <input type="checkbox"/> Assistance <input type="checkbox"/> Difficult to perform task without help <input type="checkbox"/> Assistive devices not readily available <input type="checkbox"/> Assistive devices not used
Supervisor will: <input type="checkbox"/> Develop/improve safety procedures and update IPP or Chemical Hygiene Plan <input type="checkbox"/> Request ergonomic evaluation <input type="checkbox"/> Order new equipment <input type="checkbox"/> Order new PPE <input type="checkbox"/> Remove equipment from use and/or repair/replace <input type="checkbox"/> Schedule preventive maintenance <input type="checkbox"/> Restrict employee before task is reassigned <input type="checkbox"/> Conduct on-site review of work activity <input type="checkbox"/> Update job safety analysis <input type="checkbox"/> Reconfigure work area <input type="checkbox"/> Communicate corrective actions to others in job category <input type="checkbox"/> Other (add additional information below)			
Investigation Complete <input type="checkbox"/>			
Preventive actions will be completed by (name):			
Expected date of completion:			

Optimizing strategies.

(12) Close Browser





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)



## (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

**WORKERS' COMPENSATION CLAIM FORM (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.

**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.**

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

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

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 oír información grabada. En la hoja cubierta de esta forma esta la explicación 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.

**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.**

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

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

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

**Employee:** 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 provée 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**

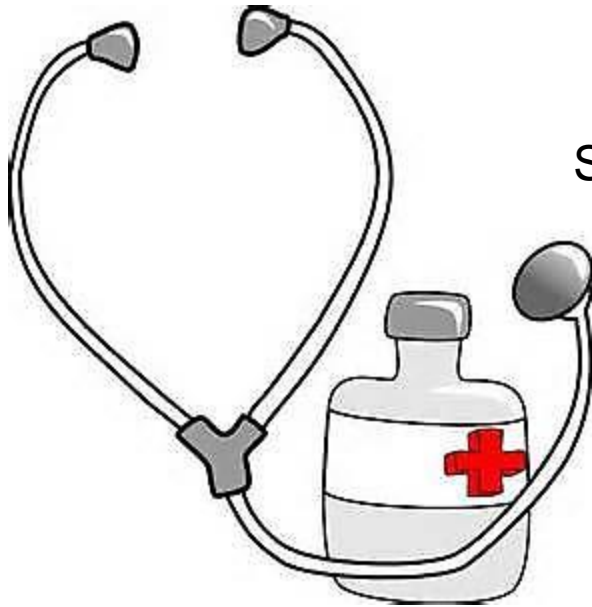
**EL FIRMAR ESTA FORMA NO SIGNIFICA ADMISION DE RESPONSABILIDAD**

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



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

Send Employee for Medical Care



# DONE!

