Electronic First Report
V2
NEW CLAIM CREATION
August 2015
New Claim Creation

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

Employer's First Report

Employer's First Report is a 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.

(2) Login to EFR
(3) Select UC Los Angeles then click on “Next”
# New Claim Creation

## 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 to 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
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.

(5) Identify who is creating the new claim.

(6) Continue to new claim

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

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(7) Enter identification information.

Employment Type is drop-down selection.
(8) Finish all entry information then continue to Part 2.
New Incident Report - Employee Information

(9) Enter incident date and incident specifics.

- **Date of injury or onset of illness:**
- **Time of injury or illness:**
- **Did the incident happen on campus?**
  - Yes
  - No
- **Location where injury or illness occurred:**
- **Were others injured?**
  - Yes
  - No
- **Body Part(s) Affected:**
(10) On Campus incidents can be identified by searchable building list.
(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 Provider:
- Occupational Health Facility (OHF)
- Brentview Medical Clinic
- Ronald Reagan Emergency Room
- Concentra
- US Healthworks
- Other
- Other (Name/Phone)

Medical treatment box will open Medical Treatment Provider detail box.

(12) Finish New Claim entry.
(13) Go To Manage Claims
New Claim Creation

(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.
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

<table>
<thead>
<tr>
<th>Employee Name</th>
<th>Address</th>
<th>City</th>
<th>State</th>
<th>Zip Code</th>
<th>Date of Injury</th>
<th>Time of Injury</th>
</tr>
</thead>
</table>

Supervisor completes 9-17

<table>
<thead>
<tr>
<th>Supervisor Name</th>
<th>Address</th>
<th>City</th>
<th>State</th>
<th>Zip Code</th>
<th>Date of Injury</th>
<th>Time of Injury</th>
</tr>
</thead>
</table>

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

1. Name, Phone number
2. Home Address, Dirección Residencial
3. City, State, Zip Code
4. Date of Injury, Fecha de la lesión (accidente)
5. Address and description of where injury happened, Dirección/dónde ocurrió 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
8. Signature of employee, FIRMA DEL EMPLEADO

Sign here: [Signature]

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Employee: You are required to date and sign this form and provide copies to your insurer or claims administrator and to the employer, employee, or representative who filled in the claim within one working day of receipt of the form by the employer.

EMPLOYER’S TEMPORARY RECEIPT

date: [Date]

signature: [Signature]

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Empleador: Se requiere que Ud. feche esta forma y la firme para que le oportunidad a su asegurador, administrador de reclamaciones, o a cualquier empleado o representante que llenó el formulario para que lo firme dentro de un día laboral desde el momento en que recibió la forma del empleador.

EL EMBARAR FORMA NO SIGNIFICA ADNICATION DE RESPONSABILIDAD

[Signature]
Give Employee 2 forms:
Claim Report
Claim Form DWC-1

Send Employee for Medical Care

DONE!