UNIVERSITY OF SOUTHERN CALIFORNIA | HUMAN RESOURCES

# Volunteer's Injury or Illness Report

Eligible volunteers must complete this form should they experience an injury or illness while volunteering for USC. A volunteer may be eligible for workers' compensation benefits if s/he has completed a volunteer agreement, and the injury or illness occurred while volunteering for USC.

- This form must be completed by all volunteers who experience an injury or illness while volunteering for USC, whether they choose to seek medical treatment or not
- All questions must be answered completely
- Failure to submit this information in a timely manner will delay benefits
- Submit form with completed Workers' Compensation Claim Form (DWC 1) via fax to ***(213) 740-7305***. Keep a copy of this form for home department records.

## Volunteer information

**Last name** | **First name** | **Social security number**

Female

**Date of birth** (mm/dd/yyyy) | **Gender** | **Phone number** | **Driver's license/ID number**

CA

**Address** | **City** | **State** | **Zip**

**Period of volunteer service: from** _____ **to** _____

**Volunteer services provided**

**Department for which volunteer services provided** | **Specific location(s) at which volunteer services provided**

**Volunteer agreement?** ☐ **Yes** ☐ **No** (If yes, provide copy of agreement)

**If no, why is there no agreement?**

**Were any benefits received by volunteer** (wages, tips, meals, housing, parking, gifts, etc.)**?** ☐ **Yes** ☐ **No**

**If yes, specify which benefits were provided**

**List any concurrent employment**

## Incident information

**Location of incident** (building and room)

**Address**

pm pm

**Date of incident** (mm/dd/yyyy) | **Time of incident** | **Time volunteer began work**

pm

**Date incident was reported to department** (mm/dd/yyyy) | **Time of report**

**Describe what volunteer was doing just before the incident occurred. Include the activity and any tools, equipment and material used** (for example, "using knife to cut lettuce for salad")

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## Incident information (continued)

**Describe how accident occurred. Indicate injured body part or illness involved** (for example, "knife slipped and cut left index finger")

**Indicate name and contact information of any 3rd party responsible for the incident, if applicable** (person or company)

**List names and contact information of any witnesses**

**Was work time lost as a result of this incident?** ☐ Yes ☐ No

**Has volunteer returned to volunteer work?** ☐ Yes ☐ No **If yes, when?**

**Is volunteer modified work available?** ☐ Yes ☐ No **If yes, for how long?** _____

## Treatment information

**Where was volunteer sent for treatment? Treatment provided by**

☐ Engemann Student Health Center ☐ Internal Medicine (HCC II) ☐ emergency room

☐ hospitalization ☐ other _____

**List name and address of physician who administered treatment, if applicable**

## Volunteer declination of medical treatment

☐ I decline medical treatment

☐ I understand that I may be entitled to workers' compensation benefits and medical care as a result of my work-related incident. I understand that this is a voluntary declaration and does not waive my right provided by the state of California.

☐ I agree to notify the department I am volunteering within should I need medical care at a later time.

☐ I acknowledge that I received the Workers' Compensation Claim Form (DWC-1) on _____

**Volunteer's signature** **Date**

**Manager's signature** **Date**

**Manager's employee ID number** **Phone extension**