Incident Report

Worker

Name of Employee/Volunteer: _____ Gender: [ ] Male [ ] Female

Job Title: _____

Employer: _____

Date of Incident: _____ Time of Incident: _____ [ ] am [ ] pm

Incident Location: _____

Reported to: _____ Phone: _____ Staff: [ ] Yes [ ] No

Witnesses: _____ Phone: _____ Staff: [ ] Yes [ ] No

Witnesses: _____ Phone: _____ Staff: [ ] Yes [ ] No

First Aid Given? [ ] Yes [ ] No   If yes, please indicate the type of first aid:

[ ] Ice   [ ] Washed Wound   [ ] Kept Immobile   [ ] Stopped Bleeding

[ ] Observed   [ ] Applied Splint   [ ] Applied Dressing   [ ] Other

Do you require medical treatment beyond first aid? [ ] Yes [ ] No **If yes, please complete form 801.**

Body Part Injured*:   Using **L** for Left and **R** for Right, indicate your injuries below

HEAD	TRUNK	EXTREMITIES		OTHER
__ Ear	__ Abdomen	__ Ankle	__ Lower Arm	__ _____
__ Eye	__ Back	__ Elbow	__ Lower Leg	__ _____
__ Face	__ Chest	__ Finger	__ Thumb	__ _____
__ Head	__ Groin	__ Foot	__ Toes	__ _____
__ Neck	__ Shoulder	__ Hand	__ Upper Arm	__ _____
__ Scalp	__ Trunk	__ Knee	__ Wrist	__ _____

L = Left
R = Right

*Also complete attached Pain Diagram.

Type of Injury Suspected: [ ] Laceration/Abrasion   [ ] Bruise/Contusion   [ ] Sprain/Strain

[ ] Dislocation   [ ] Fracture   [ ] Concussion

[ ] Surface Cut/Scratch [ ] Burn

[ ] Other: _____

Describe how incident occurred, including events that occurred immediately before the accident: _____

_____

_____

_____

I certify, as attested by my signature below, that all information I have given is true and contains no false statements and/or misrepresentations.

Print Employee/Volunteer Name: _____

Employee Signature: _____ Date: _____

Supervisor

Date Reported: _____ Time: _____ [ ] am [ ] pm To Whom? _____

Were other workers injured? [ ] Yes [ ] No   If yes, please name: _____

Additional Comments: _____

_____

_____

I certify, as attested by my signature below, that all information I have given is true based on my knowledge of the incident.
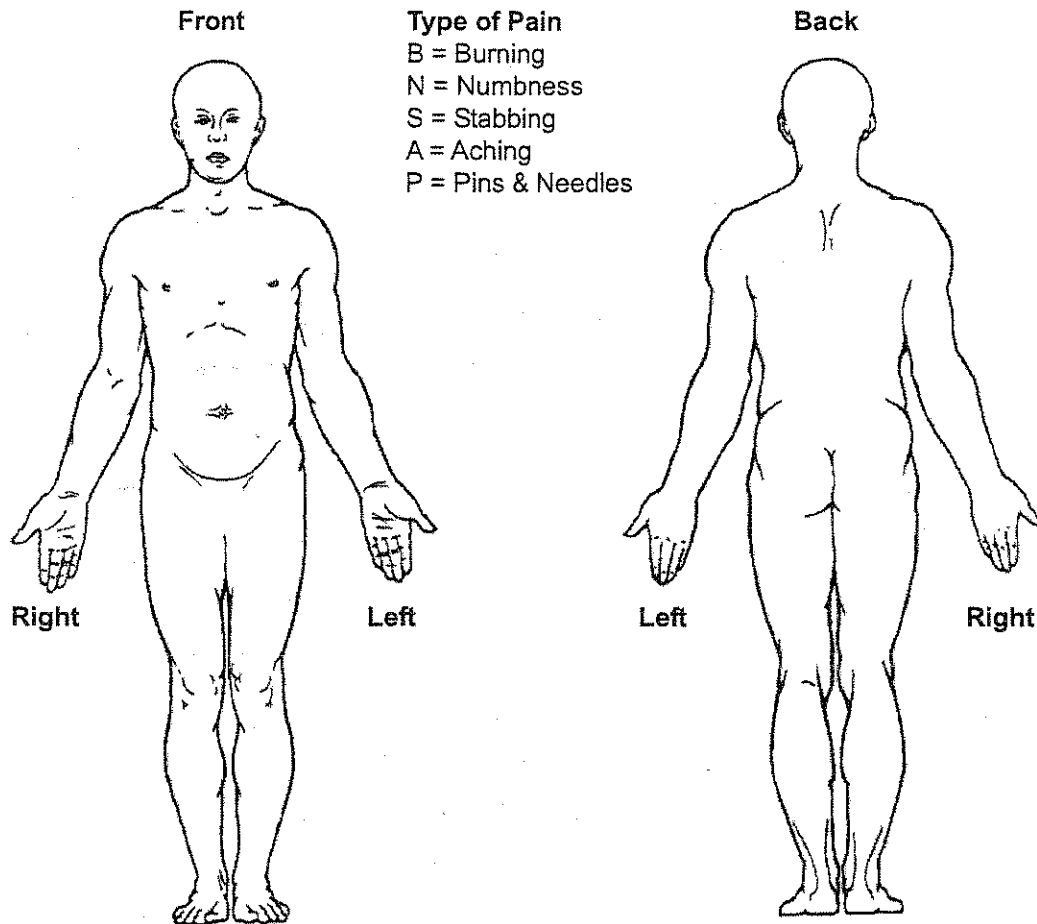
Print Supervisor Name: _____

Supervisor Signature: _____ Date: _____

Pain Diagram

This Pain Diagram needs to completed and submitted with either an **Incident Report**, an **801 Form**, or both. Mail originals to SDAO, PO Box 23879, Tigard OR 97281. Please retain a copy for your own records.

Name:_____   Employer:_____

Please mark the area of injury or discomfort on the chart below using the appropriate symbols:

Front

Type of Pain
B = Burning
N = Numbness
S = Stabbing
A = Aching
P = Pins & Needles

Back

Right   **Left**   **Left**   **Right**

0 = No Pain		Pain Scale							10 = Severe Pain	
Circle one:	0	1	2	3	4	5	6	7	8	9	10

Please use the space below to describe your condition further, if needed: _____

_____

_____

_____

I certify, as attested by my signature below, that all information I have given is true and contains no false statements and/or misrepresentations.

Print Worker's Name:_____

Worker's Signature: _____   Date: _____