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

L = Left
R = Right

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	__ ______

***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: ______________

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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: ______________________

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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: ______________________

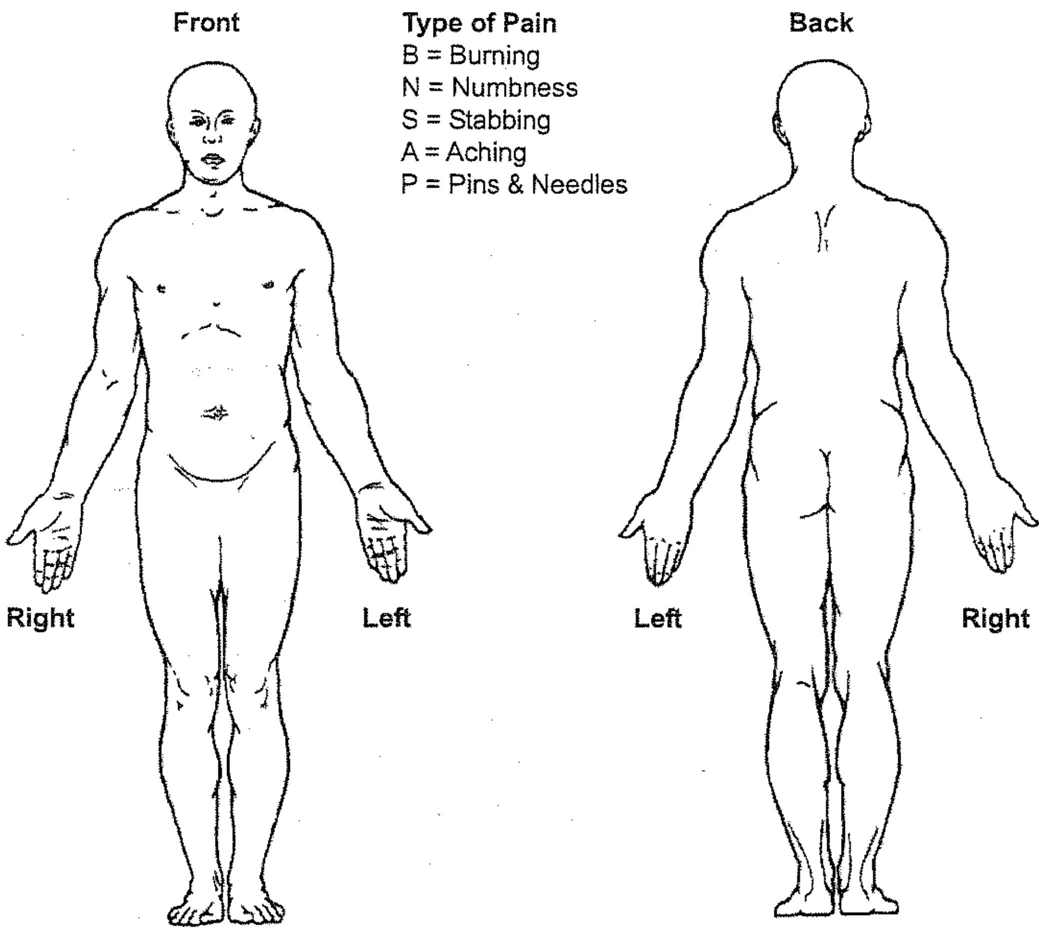
Supervisor Signature: ______________ Date: ______________

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:



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

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: ______________________

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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:______________________