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: _____

_____

_____

_____

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: _____

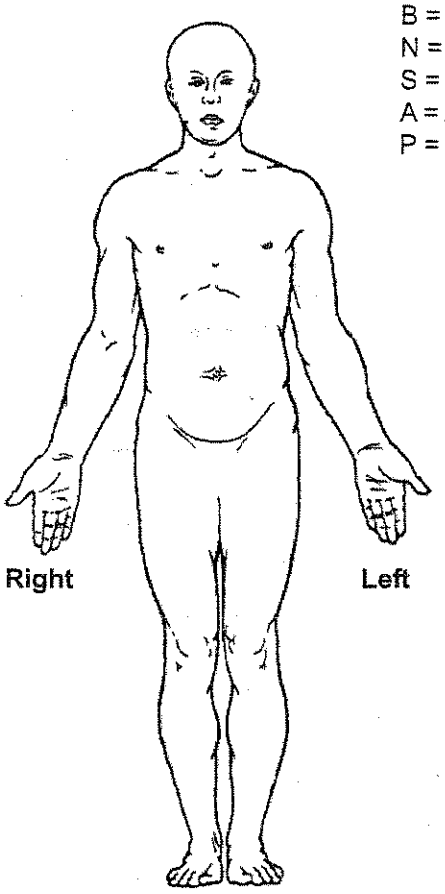
Pain Diagram

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:

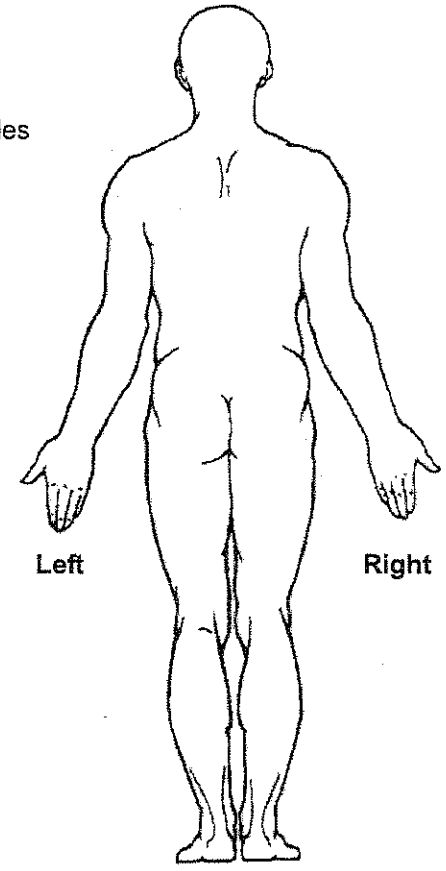
Front



Right Left

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

Back



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: _____