



OREGON DEPARTMENT OF CORRECTIONS EMPLOYEE/VOLUNTEER REPORT OF INCIDENT/NEAR-MISS/INJURY/ILLNESS



FACILITY OR UNIT: _____ DATE/TIME OF INCIDENT: ___/___/___ (AM/PM)

EMPLOYEE NAME: _____ WORK PHONE: _____
(Number To Be Reached At Work)

JOB TITLE: _____ WORKING SHIFT: _____ (AM/PM) TO: _____ (AM/PM)

SCHEDULED DAYS OFF: MON. ___ TUES. ___ WED. ___ THURS. ___ FRI. ___ SAT. ___ SUN. ___

WILL YOU COMPLETE YOUR SHIFT? YES ___ NO ___ DOCTORS CARE NEEDED? YES ___ NO ___ UNSURE ___

NAME OF SUPERVISOR CONTACTED: _____

WHEN DID YOU TELL YOUR SUPERVISOR ABOUT THE INJURY/ILLNESS? DATE _____ TIME _____
(AM/PM)

WITNESSES: _____

Please check and/or circle to describe injured part of the body.

- | | | | |
|---|-------|------|--|
| <input type="checkbox"/> Head | | | <input type="checkbox"/> Abdomen |
| <input type="checkbox"/> Face | | | <input type="checkbox"/> Back Upper Lower |
| <input type="checkbox"/> Eyes | Right | Left | <input type="checkbox"/> Hip(s) Right Left |
| <input type="checkbox"/> Neck | | | <input type="checkbox"/> Leg Right Left |
| <input type="checkbox"/> Shoulder | Right | Left | <input type="checkbox"/> Knee Right Left |
| <input type="checkbox"/> Chest | | | <input type="checkbox"/> Ankle Right Left |
| <input type="checkbox"/> Arm(s) | Right | Left | <input type="checkbox"/> Foot Right Left |
| <input type="checkbox"/> Elbow | Right | Left | <input type="checkbox"/> Toe(s) Right Left |
| <input type="checkbox"/> Hand | Right | Left | <input type="checkbox"/> Broken Glasses |
| <input type="checkbox"/> Wrist | Right | Left | <input type="checkbox"/> |
| <input type="checkbox"/> Finger(s) | Right | Left | <input type="checkbox"/> |
| <input type="checkbox"/> Other (list) _____ | | | <input type="checkbox"/> |

Please check for Type of Injury.

- Abrasion
- Cut
- Puncture
- Crush/Bruise
- Fracture
- Sprain/Strain
- Dislocation
- Burn
- Irritation
- Occupational Illness
- Other (list) _____

WAS FIRST AID APPLIED? YES ___ NO ___ IF YES, BY WHOM: _____

LOCATION WHERE INJURY OCCURRED (building, room, etc.): _____

EMPLOYEE DESCRIPTION OF INCIDENT/NEAR-MISS/INJURY/ILLNESS (Provide complete details, including; what you were doing prior to the incident/injury/illness, what materials/objects/machines were involved, what inmates were involved, etc.) _____

EMPLOYEE SIGNATURE: _____ DATE: _____

**YOU MUST NOTIFY YOUR SUPERVISOR IMMEDIATELY OF THIS INJURY/ILLNESS.
IF YOU SEEK MEDICAL TREATMENT, NOTIFY YOUR SUPERVISOR and REQUEST A SAIF
801 CLAIM FORM IF YOU INTEND TO FILE A WORKERS COMPENSATION CLAIM.
UPON COMPLETING THIS FORM, GIVE IT TO YOUR SUPERVISOR, KEEPING A COPY FOR YOUR RECORDS.**



OREGON DEPARTMENT OF CORRECTIONS SUPERVISOR'S ANALYSIS OF INCIDENT/NEAR-MISS/INJURY/ILLNESS



SUPERVISOR(S) SHALL IMMEDIATELY CONDUCT A COMPLETE ANALYSIS OF THE INCIDENT, NEAR-MISS, INJURY, OR ILLNESS. ANALYSIS SHALL INCLUDE: TALKING WITH WITNESSES, ENVIRONMENTAL CONDITIONS OF THE WORK AREA, AND A WALK THROUGH OF THE INCIDENT WITH THE EMPLOYEE TO DETERMINE CAUSE AND TO CORRECT HAZARDOUS CONDITIONS OR UNSAFE WORK PRACTICES.

SUPERVISORS ACCOUNT OF INCIDENT: _____

- Unsafe Acts**
- Operating at Unsafe Speed
 - Using Unsafe Equipment
 - Taking Unsafe Position
 - Poor Lifting Position or Placement
 - Failure to Take Precautions
 - Failure to USE Personal Protective Equipment
 - Slips or Falls
 - Distraction
 - Carelessness
 - Other (explain) _____

- Unsafe Conditions**
- Improperly Guarded Equipment
 - Improper Lighting
 - Unsafe Design or Construction
 - Hazardous Exposure
 - Hazardous Storage or Arrangement
 - Defective Tools, Equipment, etc.
 - No Personal Protective Equipment
 - Combative Inmate
 - Combative Visitor
 - Other _____

REASON FOR UNSAFE ACT (Lack of training, carelessness, etc.): _____

REASON FOR UNSAFE CONDITION: _____

HOW COULD THIS INCIDENT/NEAR-MISS BEEN AVOIDED: _____

WITNESS(ES) STATEMENT(S) (Attach sheets if needed): _____

CORRECTIVE ACTIONS (To prevent re-occurrence and/or correct hazardous conditions.): _____

IF YOU HAVE REASON TO BELIEVE THE INJURY ***MAY NOT*** BE WORK RELATED, PLEASE EXPLAIN: _____

SUPERVISORS SIGNATURE: _____ DATE: _____

**IT IS THE SUPERVISORS RESPONSIBILITY TO NOTIFY THE ASSIGNED SAFETY
MANAGER OF THIS INCIDENT, INJURY, and/or ILLNESS.**

CC: EMPLOYEE
 IMMEDIATE SUPERVISOR
 SAFETY MANAGER