

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

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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

___ Ear

___ Eye

___ Face

___ Head

___ Neck

___ Scalp

TRUNK

___ Abdomen

___ Back

___ Chest

___ Groin

___ Shoulder

___ Trunk

EXTREMITIES

___ Ankle

___ Elbow

___ Finger

___ Foot

___ Hand

___ Knee

___ Lower Arm

___ Lower Leg

___ Thumb

___ Toes

___ Upper Arm

___ Wrist

OTHER

___ _____

___ _____

___ _____

___ _____

___ _____

___ _____

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: _____

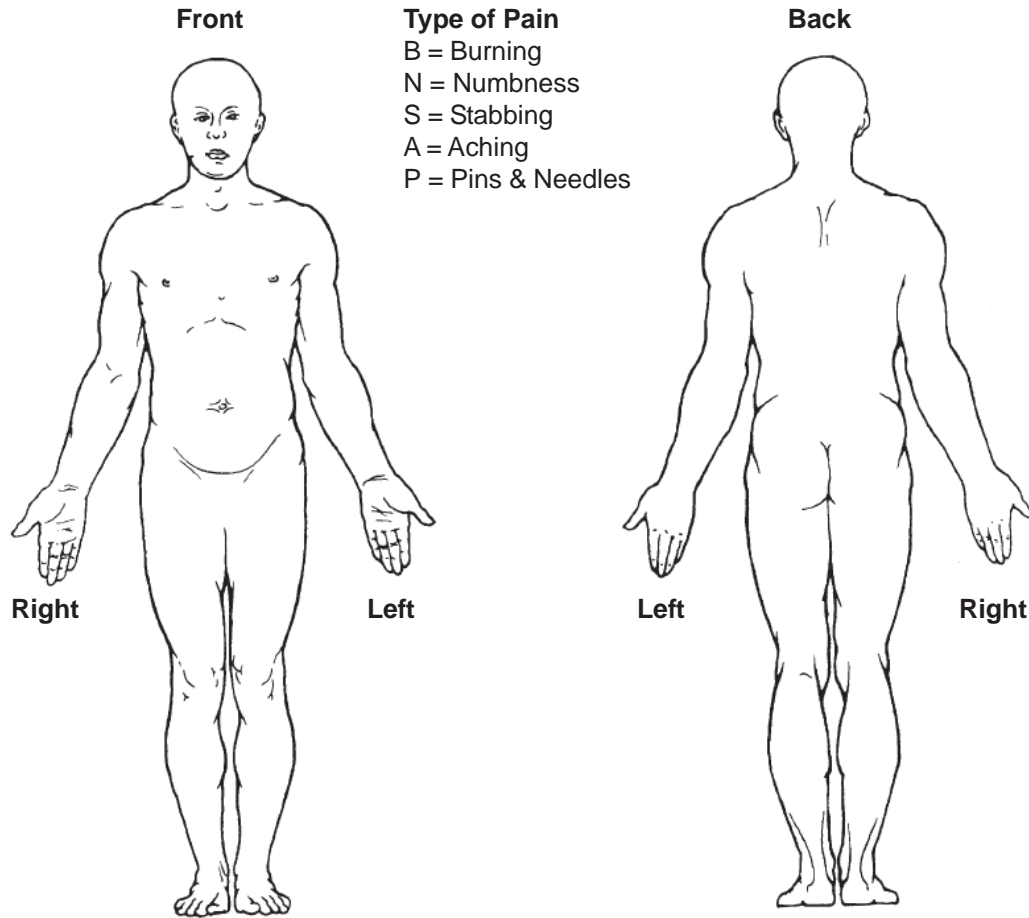
Supervisor Signature: _____ Date: _____

Pain Diagram

This Pain Diagram needs to be 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:



	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: _____