Name of Entity
Employee Accident/Incident Report

All overnight hospitalizations must be reported to OR-OSHA within 24 hours. Any fatality or catastrophes involving 3 or more hospitalizations must be reported within 8 hours. Contact OR-OSHA at (800) 922-2689.

PLEASE COMPLETE ALL OF THE FOLLOWING INFORMATION:

Employee Name: _____ **Incident RPT #:** _____

Dept: _____ **Job Title:** _____

To Be Completed By Employee:

(Attach second page if more space is required)

When did the Incident Occur? Date: _____ **Time:** _____ ☐ **a.m.** ☐ **p.m.**

Accident/Incident Location: _____

When was Incident Reported?: Date _____ **To Whom :** _____

Witnesses Information:
Witness #1 (Name, Phone): _____
Witness #2 (Name, Phone): _____

List all Parts of the Body Affected: _____ ☐ **Left side** ☐ **Right side**

Type of Injury/Illness/Exposure: (i.e. strain, cut): _____

What were you doing just before the Incident occurred? _____

Describe what happened (include sequence of events; equipment, materials, and substances being used; and environment – PLEASE BE SPECIFIC): _____

_____

_____

Was the Incident caused by defective equipment, another person, or during training? ☐ **Yes** ☐ **No**
If yes, equipment info, name of person (suspect) or instructor name: _____

Reporting information (If known and applicable): Vehicle #: _____ **Case#:**_____

Have you injured this part(s) of your body previously or is there any pre-existing condition that could affect the injury? Yes _____ **No** _____ **(if yes, please explain):**_____

_____

What do you think can be done to prevent this Incident from reoccurring? _____

_____

If seeking medical attention or unable to return-to-work, complete form 801 (Report of Job or Illness for Workers' Compensation Claim).

Employee's Signature: _____ **Date:** _____

Distribution of Copies: Original: ***Entity Contact*** within 24 hrs **1st copy:** Employee **2nd copy:** Supervisor **3rd Copy:** Safety Committee

To Be Completed By Employee's Site Supervisor:

What was the Root Cause of this Incident?

☐ **Lack of Training** ☐ **Supervision** ☐ **Rule Enforcement** ☐**Maintenance** ☐ **Other** _____
_____

What was the Surface Cause of this Incident?

☐ **Unguarded Machine** ☐ **Broken Tools** ☐ **Defective PPE** ☐ **Horseplay** ☐ **Fails to Enforce**
☐ **Other**_____

Did worker report incident within 24 hours? ☐ **Yes** ☐ **No**

Supervisor Review of Incident and Findings: _____
_____

What could have been done, or should be done, to prevent this accident/incident?: _____
_____
_____

Site Supervisor's Signature: _____ **Date:** _____

Department Head Signature: _____ **Date:** _____

Safety Committee Evaluation of Accident/Incident:

Corrective Action Needed: _____
_____

Committee Recommendations: _____
_____
_____

Estimated cost: $_____

Safety Committee Chair Signature: _____ **Date:**_____

Administrator Signature of Approval: _____ **Date:** _____

Comments:_____
_____

Safety Committee Follow-up:

Corrective Action Assigned To (if applicable): _____

Date Completed: _____