# *CITY OF CANNON BEACH*

*P.O Box 368, Cannon Beach, Oregon 97110*
*503-436-1581 ● Fax 503-436-2050*

## ***Employee Work Related Injury Incident Report***

**PLEASE COMPLETE ALL OF THE FOLLOWING INFORMATION AND RETURN TO SUPERVISOR WITHIN 24 HOURS FROM THE TIME OF INJURY.**

**Employee Name:** _____ **Location:** _____
**Job Title:** _____ **Date of Hire:** _____
**Date of Accident/Incident:** _____ **Time of Accident/Incident:** _____
**Date Reported:** _____ **To Whom Reported:** _____
**Dates of Work Lost:** _____ **Supervisor:** _____
**Accident /Incident Location:** _____ **801 Claim Form Filed? Y ( ) N ( )**
Complete if medical treatment sought or time lost from work

### Parts of Body Affected

| Head/Neck | Left Side | Right Side |
|---|---|---|
| ( ) Scalp | ( ) | ( ) |
| ( ) Neck | ( ) | ( ) |
| ( ) Ears | ( ) | ( ) |
| ( ) Eyes | ( ) | ( ) |
| ( ) Mouth | ( ) | ( ) |
| ( ) Teeth | ( ) | ( ) |
| ( ) Face | ( ) | ( ) |

| Upper Extremities | Left Side | Right Side |
|---|---|---|
| ( ) Shoulder | ( ) | ( ) |
| ( ) Upper Arm | ( ) | ( ) |
| ( ) Elbow | ( ) | ( ) |
| ( ) Forearm | ( ) | ( ) |
| ( ) Wrist | ( ) | ( ) |
| ( ) Hand | ( ) | ( ) |
| ( ) Fingers | ( ) | ( ) |

| Lower Extremities | Left Side | Right Side |
|---|---|---|
| ( ) Thigh | ( ) | ( ) |
| ( ) Lower Leg | ( ) | ( ) |
| ( ) Knee | ( ) | ( ) |
| ( ) Ankle | ( ) | ( ) |
| ( ) Foot/Toes | ( ) | ( ) |

| Trunk | Left Side | Right Side |
|---|---|---|
| ( ) Lower Back | ( ) | ( ) |
| ( ) Upper Back | ( ) | ( ) |
| ( ) Chest | ( ) | ( ) |
| ( ) Abdomen | ( ) | ( ) |
| ( ) Hip | ( ) | ( ) |
| ( ) Groin | ( ) | ( ) |

**Names of Witnesses: (Please provide witness information on a separate sheet of paper)**

_____
_____
_____
_____

### Nature of Injury

( ) Cut
( ) Scrape
( ) Bruise
( ) Skin Rash
( ) Numbness
( ) Inflammation
( ) Jammed Finger or Toe
( ) Foreign Body in Eye or Sliver
( ) Burn
( ) Electric Shock
( ) Difficulty Breathing
( ) Pain in BodyPart Identified at Left
( ) Dizziness
( ) Other: _____

### Contributing Factors

( ) Machinery Defect (Save defective parts & pieces)
( ) Tool or Equipment Broke (Save broken parts & pieces)
( ) Equipment Guarding
( ) Proper Tools/Equipment Not Available
( ) Floor, Work Surface, or Walking Surface
( ) Housekeeping
( ) Lighting
( ) Clothing or Jewelry
( ) Improper Ergonomics
( ) Other: _____

### Work Behavior At Time of Injury

*(Please check all items that pertain)*
( ) Lifting
( ) Carrying
( ) Reaching
( ) Pushing
( ) Pulling
( ) Bending or Twisting (circle correct item)
( ) Running
( ) Stepping(walking or moving from one level to another)
( ) Typing / Office Related Repetitive Motion
( ) Other Repetitive Motion Tasks
( ) Jumping
( ) Driving (If so, what vehicle?)
( ) Operating Equipment
( ) Innocent Bystander
( ) Other _____

**Safety Equipment/ Personal Protective Equipment In Use At Time of Accident/Incident:**

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

**How long have you been doing this particular job?:** _____

**Have you had any similar incidents in the past? Yes** _____ **No** _____ **(If yes, please describe by including date, type of incident, and if any action was taken):** _____

**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?** _____

## To Be Completed By Employee's Supervisor:

**Why did the accident/incident happen or the condition exist?** _____

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

**Have there been accidents or incidents in this same activity? Was action taken?** _____

******Please Provide Witness Information On A Separate Piece of Paper******

**Employee's Signature:** _____ **Date:** _____
**Supervisor's Signature:** _____ **Date:** _____
**Risk Manager's Signature:** _____ **Date:** _____

## SAFETY COMMITTEE EVALUATION OF ACCIDENT/INCIDENT

**Corrective Action Needed:** _____

**Corrective Action Assigned To (if applicable):** _____

**Date Corrective Action Completed:** _____

**Committee Recommendations:** _____