Print Form

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: _____

Special Districts Association of Oregon · PO Box 23879 · Tigard OR 97281
Phone: 503.670.7066 · Toll-free: 800.305.1736 · Fax: 503.620.6217

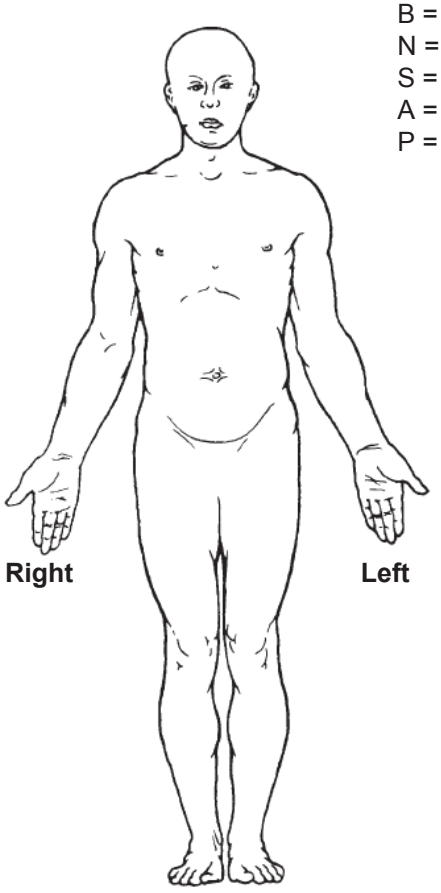
Pain Diagram

This Pain Diagram needs to completed and submitted with either an **Incident Report**, an **801 Form**, or both. Mail the completed 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

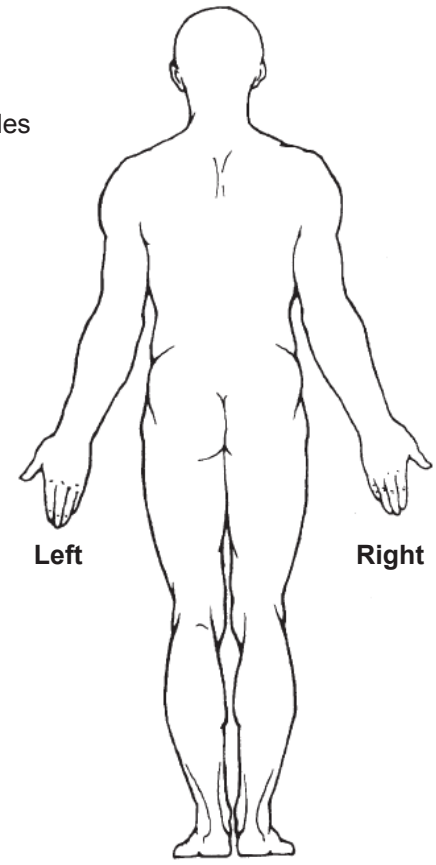


Right **Left**

Type of Pain

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

Back



Left **Right**

Pain Scale

0 = No Pain *10 = Severe Pain*

Check 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: _____

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