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

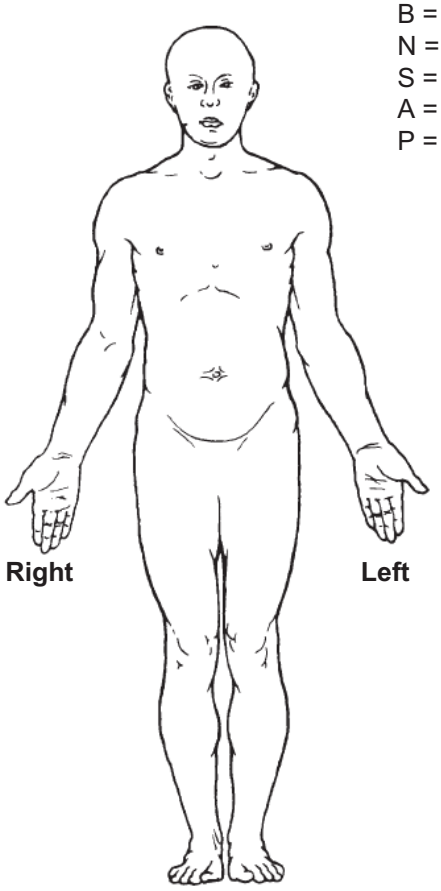
Pain Diagram

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:

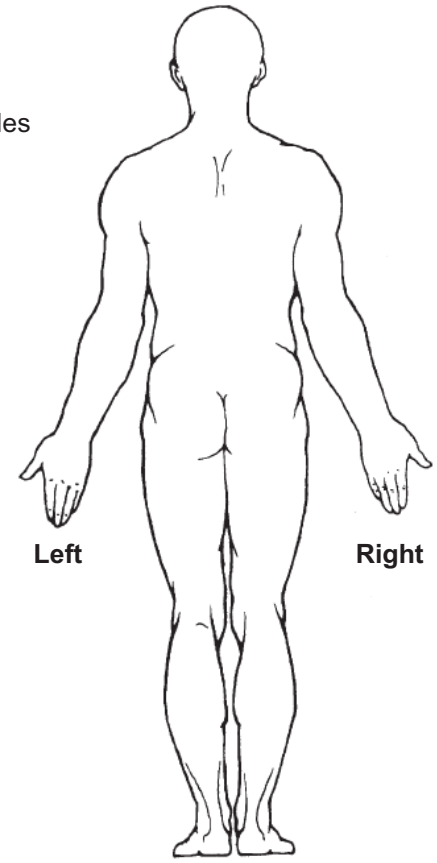
Front



Type of Pain

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

Back



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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