JEFFERSON COUNTY EMPLOYEE WORK RELATED ACCIDENT/INCIDENT INVESTIGATION REPORT

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

Employee Name: _____ Department: _____
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	◯	◯

Lower Extremities	Left Side	Right Side
◯ Thigh	◯	◯
◯ Lower Leg	◯	◯
◯ Knee	◯	◯
◯ Ankle	◯	◯
◯ Foot/Toes	◯	◯

Upper Extremities	Left Side	Right Side
◯ Shoulder	◯	◯
◯ Upper Arm	◯	◯
◯ Elbow	◯	◯
◯ Forearm	◯	◯
◯ Wrist	◯	◯
◯ Hand	◯	◯
◯ Fingers	◯	◯

Trunk	Left Side	Right Side
◯ Lower Back	◯	◯
◯ Upper Back	◯	◯
◯ Chest	◯	◯
◯ Abdomen	◯	◯
◯ Hip	◯	◯
◯ Groin	◯	◯

Nature of Injury

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

Contributing Factors

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

Once completed please submit to hr@co.jefferson.or.us

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: _____

Witness Name: _____ Witness Phone Number: _____
Witness Name: _____ Witness Phone Number: _____
Witness Name: _____ Witness Phone Number: _____
Witness Name: _____ Witness Phone Number: _____

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? _____

_____

Employee's Signature: _____ Date: _____

Supervisor's Signature: _____ Date: _____

SAFETY COMMITTEE EVALUATION OF ACCIDENT/INCIDENT

Corrective Action Needed:

_____

Corrective Action Assigned to (if applicable):

_____

Date Corrective Action Completed:

_____

Committee Recommendations:

_____

Date Reviewed by Safety Committee_____