Incident Report

The top portion of this report is to be completed by the employee/volunteer/visitor at the time of the incident. The bottom portion is to be completed the on-duty supervisor or building administrator on the same day as the accident. Fax completed Incident Reports/Pain Diagrams to SDAO at 503-620-6217.

Filing an Incident Report does not constitute a Workers' Compensation claim. Injured employees/volunteers/visitors who go to the doctor after an Incident Report and Pain Diagram is filed must immediately notify the district that they required medical treatment beyond first aid. They must also fax a completed Form 801 and Pain Diagram to SDAO at 503-620-6217.

Employee/Volunteer/Visitor

Name of Employee/Volunteer/Visitor: _____ Gender: ◯ Male ◯ Female

Job Title: _____

District _____ Department: _____

Work Shift: _____

Date of Incident: _____ Time of Incident: _____ ◯ am ◯ pm

Incident Location: _____

Reported to: _____ Phone: _____ Staff: ◯ Yes ◯ No

Witness: _____ Phone: _____ Staff: ◯ Yes ◯ No

Witness: _____ Phone: _____ Staff: ◯ Yes ◯ No

First Aid Given? ◯ Yes ◯ No

If yes, please indicate the type of first aid:

☐ Ice ☐ Observed ☐ Washed Wound ☐ Applied Splint ☐ Kept Immobile ☐ Applied Dressing ☐ Stopped Bleeding ☐ Other: _____

Do you require medical treatment beyond first aid? ◯ Yes ◯ No

If yes, you must complete form 801 in addition to the Incident Report and Pain Diagram.

Body Part(s) Injured: Indicate your injuries below. **Also complete attached Pain Diagram.**

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	☐ _____

SUSPECTED NATURE OF INJURY:

☐ Bruise/Contusion ☐ Sprain/Strain ☐ Laceration/Abrasion ☐ Fracture ☐ Concussion ☐ Dislocation ☐ Burn ☐ Surface Cut/Scratch ☐ Other: _____

SUSPECTED CAUSE OF INJURY:

☐ Fall/Slip ☐ Push/Pull ☐ Lifting ☐ Other: _____

Describe how incident occurred, including events that occurred immediately before the accident: *(Field limited to 3 lines of text.)*

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: *(Field limited to 2 lines of text.)*

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: _____

Pain Diagram

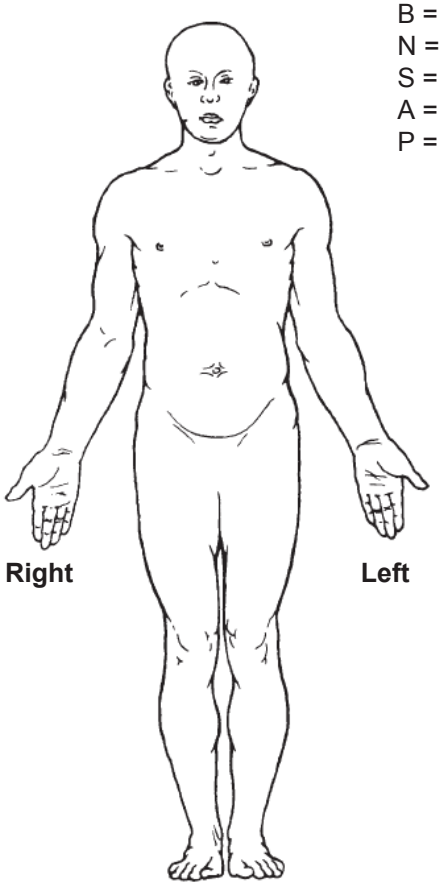
Please complete the Pain Diagram and submit along with the completed **Incident Report** or **Form 801**, or both. Retain a copy for your records and mail the completed originals to SDAO, PO Box 23879, Tigard, OR 97281.

Please Note: Completion of the Pain Diagram is voluntary and is not required to apply for workers' compensation benefits.

Name: _____ Employer: _____

Please mark the area of injury or discomfort on the chart below using the appropriate symbols:

Front

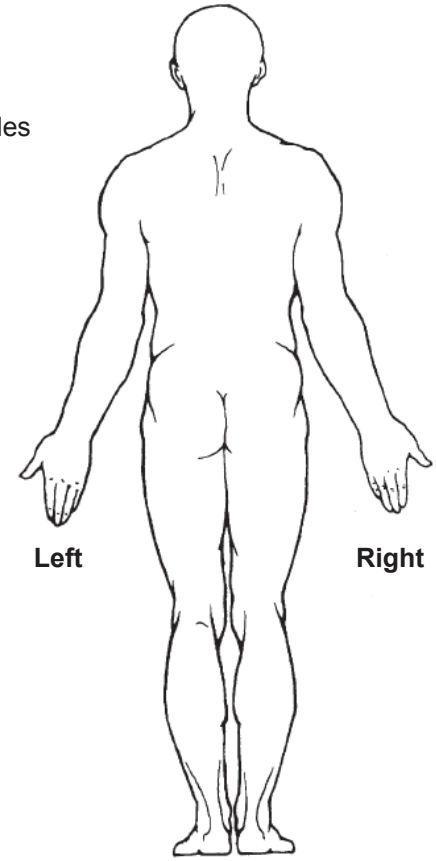


Right **Left**

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: _____

SDIS is Administered by
SDAO | PO Box 23879 | Tigard OR 97281
Toll-free: 800-305-1736 | Phone: 503-670-7066 | Fax: 503-620-6217 | E-mail: wc@sdao.com