Western Oregon UNIVERSITY

OCCUPATIONAL INJURY REPORT

- This form is to be filled out by the employee **with** their respective supervisor for **all injuries** regardless of extent.
- Must be **fully** completed within **24 hours**.
- If **injury involved doctor's treatment** or lost time, you must additionally Complete Workers' Compensation **801 Form.**
- Purpose: To provide data for the Oregon Safe Employment Act (O.S.H.A.) and WOU Risk Management.

PART I - Employee Information

Employee Name: _____
Last First Middle Initial

Employee ID# _____ Birth Date: _____ Hire Date: _____

Position Title: _____ Department: _____

Employee Category: ☐ Unclassified/Administrative ☐ Classified ☐ Temporary ☐ Student Worker

Working Days: ☐ M ☐ T ☐ W ☐ T ☐ F ☐ S ☐ S Working Hours: _____

PART II - Injury Information/ Incident Details

Incident Details

Date of Incident: _____

Time of Incident: _____

Work Status

☐ No missed work

☐ Left work early

☐ Missed work, dates: _____

Treatment

☐ No treatment
☐ Received 1st aid
☐ Will be seeking medical treatment
☐ Received medical treatment
(Workers' Compensation Form 801 attached)
☐ Hospital transport*
☐ Fatality*
☐ Other _____

Blood

Was blood present**? ☐ Yes ☐ No

Was anyone else exposed to blood? ☐ Yes ☐ No

If yes, who was exposed? _____

How was blood cleaned up? _____

Nature of Injury

☐ Inflammation/irritation
☐ Fall/Slip/Trip
☐ Bruise
☐ Sprain/Strain
☐ Scratches/abrasions
☐ Cut
☐ Burn
☐ Other _____

If fatality*, hospital transport, or if an employee was exposed to blood** or other potentially infectious materials, call Campus Public Safety at 503-838-8481. Incident may require medical consultation within 24 hours.

Cause of Injury

☐ Struck by: _____
☐ Burned by: _____
☐ Cut by: _____
☐ Contact with**: _____

Fall/Slip/Trip	Sprain/Strain	☐ Other
☐ Different level	☐ Lifting	_____
☐ Same level	☐ Bending/squatting	_____
☐ Floor condition	☐ Holding/carrying	_____
☐ Weather condition	☐ Pushing/pulling	_____
☐ Over object	☐ Reaching	
☐ On sidewalk/path	☐ Repetitive motion	
☐ On stairs	☐ Stairs	
☐ Walking	☐ Twisting/turning	

Body Part Affected _____ ☐ Left ☐ Right ☐ Both

Have you had a prior injury to this body part? ☐ Yes ☑ No

Incident Details

Specific Site of Incident (i.e. building room, etc.)

Task/Activity at time of Incident

Describe the Incident (List the sequence of events; what happened and why.

Were there any witnesses?

1. _____ 2. _____

Root Causes

Identify factors that may have contributed to or caused incident (check all that apply):

Supervisor and or Employee

- □ Safety procedures need to be reviewed
- □ Training needed
- □ Attention to surroundings
- □ Ergonomics or body mechanics

Equipment

- □ Improper use
- □ Proper tool not available or not used
- □ PPE (personal protective equipment) needs to be reviewed
- □ Tool/equipment in need of repair, describe:

Environment

- □ Building condition
- □ Chemicals
- □ Lighting
- □ Weather
- □ Caused by a 3rd party

Name: _____

Other/Explain

PART III – Recommendations/Prevention

What can be done to prevent this incident from happening again?

□ Training □ Maintenance/repair □ Request assistance with task □ Other

Explain: _____

Who will follow up? _____ Date to be completed: _____

PART IV - Signatures *By signing below, I certify that this information is true and correct to the best of my knowledge.*

	Print Name	Signature	Date	Phone
Employee				
Supervisor				