# *City of Oak Harbor*
# On The Job Injury Report - Employee and Supervisor's Report

☐ **INJURY** ☐ **RECEIVED FIRST AID** ☐ **NEAR MISS** ☐ **FATALITY**

**SUBMIT THIS REPORT TO HUMAN RESOURCES WITHIN 24 HOURS OF INJURY**

***Instructions: Employee completes the first section of this form for ANY on-the-job injury or accident; then submits the report to his/her supervisor for completion. IT IS NECESSARY TO BE VERY SPECIFIC FOR L & I INJURIES.***

Employee Name _____ Job Title _____ Wage _____(mo.)

Department _____ Hire Date _____ DOB _____

Date of accident_____Time of accident_____Accident location_____

Reported to_____ Date reported_____ Time reported_____

**a) Describe what happened *(including tools, equipment, materials or substances):***_____

_____

**b) What were you doing just before the incident occurred?**_____

_____

**c) What do you think caused it?**_____

_____

**d) Description of the injury *(please be specific)*:**

**Nature of injury**:

☐ slip/fall
☐ sprain/strain
☐ laceration (cut)
☐ burn
☐ contusion (bruise)
☐ fracture
☐ other (explain):

**Body location of injury** (check all that applies):

| ☐ **right** | ☐ **left** | ☐ **upper** | ☐ **lower** |
|---|---|---|---|
| ☐ eye | ☐ ear | ☐ face | ☐ respiratory |
| ☐ head | ☐ neck | ☐ shoulder | ☐ elbow |
| ☐ hand | ☐ finger(s) | ☐ wrist | ☐ arm |
| ☐ chest | ☐ trunk | ☐ back | ☐ hips |
| ☐ leg | ☐ knee | ☐ ankle | ☐ foot/toe |
| ☐ other | | | |

**Injury involved**:

☐ tools (manual/power)
☐ equipment
☐ toxic/hazardous materials
☐ fumes
☐ vehicle accident
☐ other _____

**e) Is this an aggravation of an earlier injury?** ☐ YES ☐ NO ☐ Don't know

***If Yes,*** provide approximate date_____

**f) What happened next?**

Received first aid ☐ YES ☐ NO Continued to work ☐ YES ☐ NO

Relieved of duty ☐ YES ☐ NO

***If Yes,*** were you: ☐ Sent/taken home ☐ Sent/taken to doctor/hospital by ☐ City vehicle ☐ ambulance ☐ other

Were you Treated in ER? ☐ YES ☐ NO Hospitalized overnight? ☐ YES ☐ NO

Will you miss work time? ☐ YES ☐ NO ***If Yes***, expected date of return to work_____

**g) If a vehicle/equipment was involved, what is the equipment number?**_____

**h) Was this an equipment failure?** ☐ YES ☐ NO ☐ Don't know

**i) In your opinion, did someone not employed by the City cause the accident in any way?** ☐ YES ☐ NO

***If Yes***, provide name, address, and phone # of the person: _____

_____

Print Employee Name _____

Employee's Signature _____ Date_____

## WITNESS REPORT

Names of witness(es)_____

Witness statement_____

_____

## SUPERVISOR'S REPORT

***Instructions: Employer is to review the employee's report and complete this section of the report for ANY on the job injury. Please submit this report to Human Resources within 24 hours of the employee's accident.***

**a) Describe what happened:** _____

_____

**b) What was the primary cause of the accident? (Check only one box.)**

☐ ***Environmental:*** (Such as: inadequate lighting, ventilation, unsafe design, inadequately guarded, weather conditions, distraction or the action of other people.)

☐ ***Physical Req'mts:*** (Such as: working in an awkward position, performing repetitive tasks, etc.)

☐ ***Equipment:*** (Such as: hard to operate, defective, failure, or unsafe clothing or shoes.)

☐ ***Procedural:*** (Such as: missing or unclear procedures, unaware of procedures, or insufficient instruction or training.)

☐ ***Behavioral:*** (Such as: inattention, misjudging the situation, misstep, overexertion, did not evaluate risk, or took known risk i.e., no personal protective equipment.)

☐ ***Other:*** _____

Please explain choice:_____

_____

Why or why not?_____

_____

**c) Do you question the validity of this claim?** ☐ YES ☐ NO *If Yes*, why?_____

_____

**d) What steps will be taken to prevent a reoccurrence of this type of accident?**_____

_____

Date these steps will be completed?_____

Follow-up on vehicle or facility maintenance report, if filed: _____

**Further Recommendations:**_____

_____

Print Supervisor Name _____

Supervisor's Signature _____ Date _____

*Police Routing:*
Captain Signature _____ Date _____

Chief Signature _____ Date _____

# Accident and OSHA Information Request

| Employee Information | |
|---|---|
| Employer name | |
| Employee name | |
| Employee department and position | |
| Date of hire | Social Security # |

| Injury Incident or Illness Information | | |
|---|---|---|
| Claim # (If known) | Date of injury (DOI) | Time of injury |
| Time employee began work on DOI | Date employee reported injury/illness | |
| Incident report completed ☐ Yes ☐ No | Date completed | |
| Do you question the validity of this claim? | | |
| If you question the validity or work-relatedness of this injury or illness, please explain why in detail below: | | |
| What job duty was being performed at time of injury? Is this a regular job duty for the employee? | | |
| Was the employee treated in an E.R. facility or hospitalized over-night? | | |

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HR WILL COMPLETE THIS SECTION

## Wage Information

| | |
|---|---|
| Is employee salaried? ☐ Yes ☐ No | |
| If "yes", please provide monthly salary | |

**For non-salaried employees please answer the questions regarding wage rate and work schedule. If their schedule varied please provide the average hours per day and average days per week worked for the 12 months prior to injury.**

| | | |
|---|---|---|
| Employee's base hourly pay | Hours worked per day | Days worked per week |
| ***For overtime, commissions, and bonuses please consider the 12 months prior to injury.** | | |
| Average number of overtime hours per month* | Commissions earned* | Bonuses paid* |
| Monthly employer contribution to health care benefits (medical, dental, vision) for employee and dependents | | |

## Claim Information

| | | |
|---|---|---|
| Has the worker missed work due to injury or illness? ☐ Yes ☐ No | | If "yes", list dates missed |
| Have they returned to work? ☐ Yes ☐ No | | If "yes", identify return to work date |
| Do you pay wages/salary if an employee is off work? ☐ Yes ☐ No | | Type of pay* |
| ***Types of pay: regular wages or salary, paid time off, vacation, sick, contractual, other (you will need to specify)** | | |
| Is temporary light-duty work available during recovery? ☐ Yes ☐ No | | |
| Planned light-duty job | | |
| If light-duty work is not available, please explain why | | |

## Employer Information

| | |
|---|---|
| Completed by | Date |
| Position | Phone |