



**Washington Hospitals
Workers' Compensation Program**
P.O. Box 19557, Seattle, Washington 98109
206-285-3955 Fax: 206-283-6122

OSHA Log Case
or Claim Number
(if applicable)

EMPLOYEE REPORT of INJURY, ILLNESS, or "NEAR MISS" INCIDENT

Employee: This form must be completed before end of shift in which incident occurred. Hand deliver completed form to supervisor or person in charge.

Supervisor: Immediately review and sign this form; route to facility designated contact (DC). Complete the Supervisor's Investigation Report ASAP; route to facility DC.

*Facility DC: Make and distribute internal copies as needed. **FAX, then MAIL fully completed original to Workers' Compensation Program***

SEVERITY OF INCIDENT: This is a report of (check one)		<input type="checkbox"/> DEATH	<input type="checkbox"/> LOST TIME	<input type="checkbox"/> MEDICAL TREATMENT	<input type="checkbox"/> FIRST AID ONLY	<input type="checkbox"/> NEAR MISS	
EMPLOYEE NAME			HOSPITAL/CITY				
EMPLOYEE HOME ADDRESS (Street, City, Zip)				DATE OF INJURY		<input type="checkbox"/> FULL TIME	
JOB TITLE		DEPARTMENT		SHIFT		<input type="checkbox"/> PART TIME	
WITNESS(ES)				TIME OF INJURY <input type="checkbox"/> A.M. <input type="checkbox"/> P.M.		<input type="checkbox"/> ON CALL	
				TIME YOU BEGAN WORK <input type="checkbox"/> A.M. <input type="checkbox"/> P.M.		<input type="checkbox"/> TEMPORARY WORK	
DESCRIBE INCIDENT, GIVE FULL DETAILS OF WHAT HAPPENED (Use separate piece of paper, if necessary.):							
WHAT WERE YOU DOING JUST BEFORE INCIDENT OCCURRED?							
EXACTLY WHERE WERE YOU WHEN INCIDENT OCCURRED?							
WHAT HAPPENED AND HOW DID INJURY OR INCIDENT OCCUR?							
WHAT WAS THE INJURY OR ILLNESS RESULTING FROM INCIDENT?							
WHAT OBJECT OR SUBSTANCE HURT YOU OR CAUSED A NEAR MISS?							
LIST ANY PERSONAL PROTECTIVE EQUIPMENT WORN (if applicable)?							
EMPLOYMENT?		PART OF BODY INJURED?		TYPE OF INJURY/EXPOSURES?		CAUSE OF INCIDENT?	
<input type="checkbox"/> Hospital <input type="checkbox"/> Nursing Home/LTC <input type="checkbox"/> Home Health Care <input type="checkbox"/> Ambulance <input type="checkbox"/> Clinic <input type="checkbox"/> Physician <input type="checkbox"/> Volunteer <input type="checkbox"/> Community Service		<input type="checkbox"/> Head <input type="checkbox"/> Eye <input type="checkbox"/> Nose <input type="checkbox"/> Mouth <input type="checkbox"/> Ear <input type="checkbox"/> Neck <input type="checkbox"/> Shoulder <input type="checkbox"/> Back, upper <input type="checkbox"/> Back, lower <input type="checkbox"/> Chest <input type="checkbox"/> Arm (Please indicate <input type="checkbox"/> Left or <input type="checkbox"/> Right)		<input type="checkbox"/> Wrist <input type="checkbox"/> Hand <input type="checkbox"/> Finger <input type="checkbox"/> Hip <input type="checkbox"/> Thigh <input type="checkbox"/> Knee <input type="checkbox"/> Leg <input type="checkbox"/> Ankle <input type="checkbox"/> Foot <input type="checkbox"/> Toe <input type="checkbox"/> Internal <input type="checkbox"/> Other _____		<input type="checkbox"/> Puncture Wound/Laceration <input type="checkbox"/> Foreign Body <input type="checkbox"/> Sprain/Strain <input type="checkbox"/> Hernia <input type="checkbox"/> Fracture/Dislocation <input type="checkbox"/> Infectious Disease <input type="checkbox"/> Burn/Scald <input type="checkbox"/> Irritations/Dermatitis <input type="checkbox"/> Respiratory <input type="checkbox"/> Tendonitis <input type="checkbox"/> Contusion <input type="checkbox"/> Other _____	<input type="checkbox"/> Fall From Chair or Equipment <input type="checkbox"/> Fall On Same Level <input type="checkbox"/> Fall From Different Level <input type="checkbox"/> Fall From Fainting <input type="checkbox"/> Slip On Something <input type="checkbox"/> Spill-Spray <input type="checkbox"/> Slip, no fall <input type="checkbox"/> Struck by Person <input type="checkbox"/> Struck by Equipment <input type="checkbox"/> Struck by Tool or Object <input type="checkbox"/> Pulling <input type="checkbox"/> Pushing <input type="checkbox"/> Lifting <input type="checkbox"/> Reaching or Bending <input type="checkbox"/> Exposure <input type="checkbox"/> Combative Patient <input type="checkbox"/> Overuse <input type="checkbox"/> Needle Puncture <input type="checkbox"/> Inhalation <input type="checkbox"/> Heart Attack <input type="checkbox"/> Recurrence of old injury <input type="checkbox"/> Re-injury same type/body part <input type="checkbox"/> Other _____
LOCATION OF INCIDENT?							
<input type="checkbox"/> Admitting <input type="checkbox"/> Parking Lot <input type="checkbox"/> Sidewalk <input type="checkbox"/> Laboratory <input type="checkbox"/> Restroom <input type="checkbox"/> Patient Room # _____ <input type="checkbox"/> X-Ray		<input type="checkbox"/> Emergency <input type="checkbox"/> ICU/CCU <input type="checkbox"/> Pharmacy <input type="checkbox"/> Resp. Therapy <input type="checkbox"/> Physical Therapy <input type="checkbox"/> Medical Unit <input type="checkbox"/> Surgical Unit		<input type="checkbox"/> Obstetrics <input type="checkbox"/> Pediatrics <input type="checkbox"/> Maintenance <input type="checkbox"/> Housekeeping <input type="checkbox"/> Receiving <input type="checkbox"/> Central Supply <input type="checkbox"/> Office		<input type="checkbox"/> Elevator <input type="checkbox"/> Food Services <input type="checkbox"/> Vehicle <input type="checkbox"/> Other _____	
CHECK AND COMPLETE ALL THAT APPLY BELOW:							
Did you receive first aid treatment?		<input type="checkbox"/> yes	<input type="checkbox"/> no	By whom? _____			
Were you treated by a Registered Nurse?		<input type="checkbox"/> yes	<input type="checkbox"/> no	By whom? _____			
Were you treated by a Physician?		<input type="checkbox"/> yes	<input type="checkbox"/> no	By whom? _____			
Were you treated in emergency room?		<input type="checkbox"/> yes	<input type="checkbox"/> no	Where? _____			
Did you spend overnight in hospital?		<input type="checkbox"/> yes	<input type="checkbox"/> no	Where? _____			
Will you lose time from regular work?		<input type="checkbox"/> yes	<input type="checkbox"/> no	Estimate # of Days: _____			
*** IF YOU WERE TREATED BY A PHYSICIAN OR PLAN TO SEE ONE, YOU MUST COMPLETE SIF-2 CLAIM FORM ***							
EMPLOYEE SIGNATURE			DATE		SUPERVISOR SIGNATURE		