City of Lake Oswego
Employee Accident/Incident Report

citycounty insurance services
www.cisoregon.org

All overnight hospitalizations must be reported to OR-OSHA within 24 hours. Any fatality or catastrophes involving 3 or more hospitalizations must be reported within 8 hours. Contact OR-OSHA at (800) 922-2689.

PLEASE COMPLETE ALL OF THE FOLLOWING INFORMATION:

Employee Name: _____ **Incident RPT #:** _____

Dept: _____ **Job Title:** _____

To Be Completed By Employee:

(Attach second page if more space is required)

When did the Incident Occur? Date: _____ **Time:** _____ ☐ **a.m.** ☐ **p.m.**

Accident/Incident Location: _____

When was Incident Reported?: Date _____ **To Whom :** _____

Witnesses Information:
Witness #1 (Name, Phone): _____
Witness #2 (Name, Phone): _____

List all Parts of the Body Affected: _____ ☐ **Left side** ☐ **Right side**

Type of Injury/Illness/Exposure: (i.e. strain, cut): _____

What were you doing just before the Incident occurred? _____

Describe what happened (include sequence of events; equipment, materials, and substances being used; and environment – PLEASE BE SPECIFIC): _____

_____

_____

Was the Incident caused by defective equipment, another person, or during training? ☐ **Yes** ☐ **No**
If yes, equipment info, name of person (suspect) or instructor name: _____

Reporting information (If known and applicable): Vehicle #: _____ **Case#:**_____

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? _____

_____

If seeking medical attention or unable to return-to-work, complete form 801 (Report of Job or Illness for Workers' Compensation Claim).

Employee's Signature: _____ **Date:** _____

Distribution of Copies: Original: ***Entity Contact*** within 24 hrs **1st copy:** Employee **2nd copy:** Supervisor **3rd Copy:** Safety Committee

City of Lake Oswego
Human Resources Department

380 A Avenue, PO Box 369, Lake Oswego, OR 97034
503-635-0220 Phone 503-675-3993 Fax

PERSONAL INJURY / OTHER INCIDENT REPORT FORM

A claim must be filed with the City of Lake Oswego within 180 days after the occurrence of the incident or event. Where space is insufficient, please use additional paper and identify information by section heading. For assistance or questions about this form, please contact the Human Resources department at 503-635-0220.

Name of individual completing this form: _____ Date: _____

CLAIMANT INFORMATION

Claimant Name: _____ Date: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____

Cell Phone: _____ E-mail: _____

If claimant is a minor please list parent's name: _____

INCIDENT INFORMATION

Date of Incident: _____ Location: _____

Time of Incident: _____ ☐AM ☐ PM

Type of Incident:

☐ Slip & Fall ☐ Assault ☐ Arrest ☐ Eviction ☐ Death ☐ Other : _____

Describe the injury, including actions immediate prior and after. Also include details that may have contributed to the incident including location, lighting, weather, surface type, footwear, etc. Please attach additional sheets or sketches, if needed:

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

WITNESS INFORMATION

Provide name and contact information for all witnesses. If more than three witnesses are known, please attach additional sheets.

1) Witness Name: _____ Phone: _____

Address: _____ City: _____ State: _____ Zip: _____

2) Witness Name: _____ Phone: _____

Address: _____ City: _____ State: _____ Zip: _____

3) Witness Name: _____ Phone: _____

Address: _____ City: _____ State: _____ Zip: _____

FIRST AID INFORMATION

Was first aid administered? ☐ No ☐ Yes Describe: _____

Ambulance called? ☐ No ☐ Yes Ambulance Company: _____

Hospital / Clinic Name and Location: _____

Injured Party's Personal Physician Name and Location (if known):

_____

_____

ADDITIONAL INFORMATION

Please provide any additional information that might be helpful in considering your claim:

_____

_____

_____

_____

_____

SIGNATURE

Your signature below indicates that all information provided on and attached to this form is true and correct to the best of your knowledge. Please sign and return to the Human Resources Department by fax to 503-975-3993, or by mail to PO Box 369, Lake Oswego, OR 97034.

Signature: _____ Date: _____

Print Name: _____

To Be Completed By Employee's Site Supervisor:

What was the Root Cause of this Incident?

☐ **Lack of Training** ☐ **Supervision** ☐ **Rule Enforcement** ☐ **Maintenance** ☐ **Other** _____
_____

What was the Surface Cause of this Incident?

☐ **Unguarded Machine** ☐ **Broken Tools** ☐ **Defective PPE** ☐ **Horseplay** ☐ **Fails to Enforce**
☐ **Other**_____

Did worker report incident within 24 hours? ☐ **Yes** ☐ **No**

Supervisor Review of Incident and Findings: _____
_____

What could have been done, or should be done, to prevent this accident/incident?: _____
_____
_____

Site Supervisor's Signature: _____ **Date:** _____

Department Head Signature: _____ **Date:** _____

Safety Committee Evaluation of Accident/Incident:

Corrective Action Needed: _____
_____

Committee Recommendations: _____
_____
_____

Estimated cost: $_____

Safety Committee Chair Signature: _____ **Date:**_____

Administrator Signature of Approval: _____ **Date:** _____

Comments:_____
_____

Safety Committee Follow-up:

Corrective Action Assigned To (if applicable): _____

Date Completed: _____

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PROPERTY LIABILITY REPORT FORM

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Name of individual completing this form: _____ Date: _____

CLAIMANT INFORMATION

Claimant Name: _____ Date: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____

Cell Phone: _____ E-mail: _____

If claimant is a minor please list parent's name: _____

INCIDENT INFORMATION

Date of Incident: _____ Location: _____

Time of Incident: _____ ☐AM ☐ PM

Describe the particular event you claim caused the property damage. Please attach additional sheets or sketches, if needed:

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

WITNESS INFORMATION

Provide name and contact information for all witnesses. If more than three witnesses are known, please attach additional sheets.

1) Witness Name: _____ Phone: _____

Address: _____ City: _____ State: _____ Zip: _____

2) Witness Name: _____ Phone: _____

Address: _____ City: _____ State: _____ Zip: _____

3) Witness Name: _____ Phone: _____

Address: _____ City: _____ State: _____ Zip: _____

DAMAGE INFORMATION

Describe the exact damage to the property. Please attach additional sheets or sketches, if needed:

_____
_____
_____
_____
_____

Estimated Cost to: ☐ Repair ☐ Replace $ _____

Amount Claimed as of this Date: $_____

Estimated Future Costs: $ _____

Anticipated Total Amount Claimed: $ _____

Please attach any bills, invoices, written estimates or other proof of claim damages.

ADDITIONAL INFORMATION

Please provide any additional information that might be helpful in considering your claim:

_____
_____
_____
_____
_____

SIGNATURE

Your signature below indicates that all information provided on and attached to this form is true and correct to the best of your knowledge. Please sign and return to the Human Resources Department by fax to 503-975-3993, email to smatthew@ci.oswego.or.us, or by mail to PO Box 369, Lake Oswego, OR 97034.

Signature: _____ Date: _____

Print Name: _____