

City of Lake Oswego
PO Box 369
380 A Avenue
Lake Oswego, OR 97034
Ph: (503) 635-0220 Fax: (503) 675-3993

www.ci.oswego.or.us

Citizen or Volunteer Accident/Incident Report Form

- Please fill out both sides completely at the time of the accident/incident
- See reverse side for instructions on what to do after form is completed

| |
|---|
| Incident Date ___/___/___ Time _____ am pm |
|---|

Nature of Accident/Incident:
 injury illness theft confrontation/ altercation fire property damage
 mechanical other _____

Name & address of location: _____

Name & address of person(s) involved: (I- injured/involved person, W- witness, S-staff)

| | <i>name</i> | <i>age</i> | <i>phone #</i> | <i>address</i> |
|----|---|------------|----------------|----------------|
| 1. | I W S <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> | _____ | _____ | _____ |
| | Affiliation (group/team name) _____ | | | |
| 2. | I W S <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> | _____ | _____ | _____ |
| | Affiliation (group/team name) _____ | | | |
| 3. | I W S <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> | _____ | _____ | _____ |
| | Affiliation (group/team name) _____ | | | |

Supervisor: _____ *name* _____ *phone #*
Supervisor/staff/volunteer in charge of activity: _____
Present at time of accident/incident? Y N

Description of Accident/Incident (include specifics: what were they doing, who was present, what happened afterwards, etc.)

Medical Information:

Body part(s) injured: _____ left right (describe on page 1 if necessary)
_____ left right (describe on page 1 if necessary)

Type of injury (if known): severe cut break/fracture concussion sprain dislocation

Was treatment provided on site? Y N By whom? _____

If yes, describe treatment _____

Given further medical attention? Y N
If yes, where? _____

Was parent / guardian / emergency contact notified? Y N
If yes, who was contacted, and by whom? _____

With whom did the injured party leave the site? _____
When? _____

Follow up:

Was follow up contact made? Y N By whom? _____

Who was contacted? _____ Date ___/___/___ Time _____ am pm

Status? _____

Additional Information: (anything else you feel is important to the accident/incident)

I, the undersigned, have completed this form to the best of my ability, with no willfull misrepresentations, omissions, or falsifications.

Signature Printed Name Date

Administrative Procedures:

1. Complete both sides of this form to the best of your ability, and sign above.
2. Contact your supervisor *immediately* following the accident/incident.
 - o If your supervisor is not available, call Human Resources at (503) 635-0220
 - o If it is after hours, leave a voice mail.
3. Keep a copy of this form for your Department and send the original to Human Resources Department within 24 hours of the accident/incident.