Roseburg Public Schools

EMPLOYEE INCIDENT REPORT

EMPLOYEE TO COMPLETE THIS SIDE OF FORM

Employee Name (Legal) :_____ **Job Title**:_____

School/Department:_____ **Incident/Accident Location:** _____

Incident Date:_____ **Time of Incident**:_____ **Plan to Seek Medical Treatment?** ☐ Yes ☐ No ☐ TBD

Shift on day of injury:	
From:	☐ a.m. ☐p.m
To:	☐ a.m. ☐p.m

Time missed on day of injury:		
From:	☐ a.m. ☐p.m	☐ No time missed.
To:	☐ a.m. ☐p.m	

Parts of Body Affected:	**Side(s) of Body Affected:**	
Head/Neck	Left	Right
Scalp/Skull	☐	☐
Neck	☐	☐
Ear(s)	☐	☐
Eye(s)	☐	☐
Mouth	☐	☐
Teeth	☐	☐
Nose	☐	☐
Face (Specify):	☐	☐
Upper Extremities	Left	Right
Arm	☐	☐
Hand	☐	☐
Shoulder	☐	☐
Wrist	☐	☐
Finger(s)	☐	☐
Lower Extremities	Left	Right
Thigh	☐	☐
Lower Leg	☐	☐
Knee	☐	☐
Ankle	☐	☐
Foot	☐	☐
Toes	☐	☐
Trunk	Left	Right
Lower Back	☐	☐
Upper Back	☐	☐
Chest	☐	☐
Abdomen	☐	☐
Hip	☐	☐
Groin	☐	☐

Nature of Injury:		**Do you have any pre-existing condition, injury, disease, or similar issue affecting this part or parts of the body that could cause or contribute to the disabling incident, or contribute to a need to seek medical treatment?**
☐ Cut	☐ Scrape	☐ Yes ☐ No
☐ Fracture	☐ Surface wound	
☐ Open Wound	☐ Bruising	
☐ Skin Rash	☐ Burn or Electric Shock	
☐ Foreign Body	☐ Localized Pain	
☐ Inflammation	☐ Jammed Finger or Toe ☐ Loss of Consciousness	
☐ Difficulty Breathing	☐ Twist ☐ Other:	

Employee description of the incident:

Employee Signature:_____ Date: _____

BUILDING SAFETY ASSESSMENT

Directions: If any information has changed since the employee originally completed the incident report, complete section I. If no changes noted, skip to section II. The designated Building Safety Committee Team Inspector should complete the applicable sections. Any assessments referred to the Designated Central Office Safety Committee "Safety Committee Chair" must be reviewed by the employee's supervisor as soon as possible.

SECTION I: EMPLOYEE INFORMATION UPDATES

Employee Name: _____

Is the employee expected to seek medical attention due to the incident?

☐ Yes ☐ Likely ☐ No ☐ Unlikely ☐ TBD

Due to the employee's injury or incident, did the employee:

Leave work on the day of the injury? ☐ Yes ☐ No

Miss work after the day of their injury? ☐ Yes ☐ No

Placed on any work restrictions? ☐ Yes ☐ No

Provide IF APPLICABLE:

Time employee left work on day of injury:

_____: _____ ☐ AM ☐ PM

Date(s) missed or anticipated to miss work:

SECTION II: SUMMARY OF FACTS

Ask witness(es) to tell you what happened and provide their name(s) along with any new information below:

Witness 1:

Witness 2:

Provide any additional information, if applicable. Focus on the event facts; avoid making assumptions. Consider what happened before, during, and after the event:

Contributing Factors *Other*: _____

☐ Skin Contact ☐ Noise ☐ Temperature ☐ Overexertion ☐ Repetitive Motion ☐ Ventilation ☐ Loss of Balance

☐ Jagged Edges ☐ Sharp Object(s) ☐ Clutter ☐ Obstruction(s) ☐ Workplace Cleanliness ☐ General Housekeeping

☐ Available PPE (Unused) ☐ Available PPE (Unavailable) ☐ Inattentiveness ☐ Recklessness ☐ Horseplay

☐ Clothing, Shoes or Jewelry ☐ Unsafe Lifting ☐ Awkward Posture ☐ Spills/ Leaks ☐ Lighting /Visibility

☐ Unsecured / Loose Objects ☐ Stairs / Ladders ☐ Barriers / Gates ☐ Exposure to substance

☐ Equipment Guarding ☐ Altered or Inappropriate equipment ☐ Machinery Defect (Save parts and pieces) ☐ Safety Device Bypassed

☐ Weather/Road Conditions ☐ Tool/Equipment Availability ☐ Floor, Work Surface, or Walking Surface

Prevention Recommendation(s): *Other:* _____

☐ Improve Housekeeping ☐ Safety Device(s) ☐ PPE Availability ☐ Ergonomic Equipment

☐ Repair or Replace Equipment ☐ Improve Equipment Design ☐ Supervisory Support

☐ Establish Rule(s)/Procedure(s) ☐ Job Safety Analysis ☐ Training

☐ **Safety Committee Chair Notification**: Provide a copy of both pages to the chair as soon as possible.

Safety Team Investigator Signature _____ **Date** _____

Supervisor Signature _____ **Date** _____