

# UNIVERSITY OF OREGON WORKPLACE INJURY OR ILLNESS REPORT

Safety and Risk Services  
1260 University of Oregon  
1715 Franklin Blvd., Suite 2A

Phone: 541-346-8316  
Fax: 855-658-7729  
[workinjury@uoregon.edu](mailto:workinjury@uoregon.edu)

**Instructions:** To be completed by employee with a lead staff member, supervisor or manager **WITHIN 24 HOURS** of when employee reports a work-related injury, illness, or near miss. **Complete ALL sections**, do not leave any blanks.

Department \_\_\_\_\_ Date of Report \_\_\_\_\_

Date of Incident \_\_\_\_\_ Time of Incident \_\_\_\_\_ a.m. or p.m.  
or Illness \_\_\_\_\_ or Illness \_\_\_\_\_

## Employee Information:

Employee Name \_\_\_\_\_  
Last First MI

Employee ID# \_\_\_\_\_ Birth Date \_\_\_\_\_ Position Title \_\_\_\_\_

Employee Category     Regular, full-time             Temporary UO             Student Worker  
                                   Regular, part-time             Temporary Agency        Volunteer

Working Days                      Working Hours \_\_\_\_\_  
                                  M   T   W   T   F   S   S

## Injury Information:

<div style="border: 1px solid black; padding: 2px; margin-bottom: 5px;"><b>Nature of Injury or Illness</b></div> <input type="checkbox"/> Burn <input type="checkbox"/> Inflammation/irritation <input type="checkbox"/> Bruise <input type="checkbox"/> Scratches/abrasions <input type="checkbox"/> Cut <input type="checkbox"/> Sprain/strain <input type="checkbox"/> No Injury <input type="checkbox"/> Other _____  Body Part Affected _____ <input type="checkbox"/> Left <input type="checkbox"/> Right <input type="checkbox"/> Both	<div style="border: 1px solid black; padding: 2px; margin-bottom: 5px;"><b>Cause of Injury or Illness</b></div> <input type="checkbox"/> Burned by: _____ <input type="checkbox"/> Cut by: _____ <input type="checkbox"/> Contact with: _____ <input type="checkbox"/> Struck by: _____  <table style="width: 100%; border: none;"> <tr> <td style="border: none;"><u>Fall/Slip/Trip</u></td> <td style="border: none;"><u>Sprain/Strain</u></td> <td style="border: none;"><input type="checkbox"/> <u>Other</u></td> </tr> <tr> <td style="border: none;"><input type="checkbox"/> Different level</td> <td style="border: none;"><input type="checkbox"/> Lifting</td> <td style="border: none;">_____</td> </tr> <tr> <td style="border: none;"><input type="checkbox"/> Same level</td> <td style="border: none;"><input type="checkbox"/> Bending/squatting</td> <td style="border: none;">_____</td> </tr> <tr> <td style="border: none;"><input type="checkbox"/> Floor condition</td> <td style="border: none;"><input type="checkbox"/> Holding/carrying</td> <td style="border: none;">_____</td> </tr> <tr> <td style="border: none;"><input type="checkbox"/> Weather condition</td> <td style="border: none;"><input type="checkbox"/> Pushing/pulling</td> <td style="border: none;">_____</td> </tr> <tr> <td style="border: none;"><input type="checkbox"/> Over object</td> <td style="border: none;"><input type="checkbox"/> Reaching</td> <td style="border: none;"></td> </tr> <tr> <td style="border: none;"><input type="checkbox"/> On sidewalk/path</td> <td style="border: none;"><input type="checkbox"/> Repetitive motion</td> <td style="border: none;"></td> </tr> <tr> <td style="border: none;"><input type="checkbox"/> On stairs</td> <td style="border: none;"><input type="checkbox"/> Stairs</td> <td style="border: none;"></td> </tr> <tr> <td style="border: none;"><input type="checkbox"/> Footwear</td> <td style="border: none;"><input type="checkbox"/> Twisting/turning</td> <td style="border: none;"></td> </tr> <tr> <td style="border: none;"><input type="checkbox"/> Rushing</td> <td style="border: none;"><input type="checkbox"/> Walking</td> <td style="border: none;"></td> </tr> </table>	<u>Fall/Slip/Trip</u>	<u>Sprain/Strain</u>	<input type="checkbox"/> <u>Other</u>	<input type="checkbox"/> Different level	<input type="checkbox"/> Lifting	_____	<input type="checkbox"/> Same level	<input type="checkbox"/> Bending/squatting	_____	<input type="checkbox"/> Floor condition	<input type="checkbox"/> Holding/carrying	_____	<input type="checkbox"/> Weather condition	<input type="checkbox"/> Pushing/pulling	_____	<input type="checkbox"/> Over object	<input type="checkbox"/> Reaching		<input type="checkbox"/> On sidewalk/path	<input type="checkbox"/> Repetitive motion		<input type="checkbox"/> On stairs	<input type="checkbox"/> Stairs		<input type="checkbox"/> Footwear	<input type="checkbox"/> Twisting/turning		<input type="checkbox"/> Rushing	<input type="checkbox"/> Walking	
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<div style="border: 1px solid black; padding: 2px; margin-bottom: 5px;"><b>Treatment</b></div> <input type="checkbox"/> Received 1 <sup>st</sup> aid <input type="checkbox"/> Will be seeking medical treatment <input type="checkbox"/> Received medical treatment (to file a workers' compensation claim complete 801 form) <input type="checkbox"/> Hospital transport* <input type="checkbox"/> Fatality* <input type="checkbox"/> No treatment <input type="checkbox"/> Other _____	<div style="border: 1px solid black; padding: 2px; margin-bottom: 5px;"><b>Blood**</b></div> Was blood present? <input type="checkbox"/> Yes <input type="checkbox"/> No  If yes, was anyone exposed to blood? <input type="checkbox"/> Yes** <input type="checkbox"/> No  <b>**If an employee was exposed to another person's blood or bodily fluids, please refer to exposure procedures at <a href="http://safety.uoregon.edu/bloodborne-pathogens">safety.uoregon.edu/bloodborne-pathogens</a></b>																														
<div style="border: 1px solid black; padding: 2px; margin-bottom: 5px;"><b>Work Status</b></div> <input type="checkbox"/> Left work early <input type="checkbox"/> Missed work, dates: _____ <input type="checkbox"/> No missed work																															

\*If fatality or hospital transport, call Safety and Risk Services **immediately** at 541-346-3192.

<b>Incident Details:</b>				
<b>Specific Site of Incident or Illness</b> (i.e. building, room)				
<b>Task/Activity at Time of Incident or Illness</b>				
<b>Witness(es) (name and contact information)</b>				
<b>Describe Incident or Illness</b> List the sequence of events; what happened and why:				
<b>Root Causes:</b>				
<b>Identify factors that may have contributed to or caused incident or illness (check all that apply):</b>				
<u>Management</u>	<u>Environment</u>			
<input type="checkbox"/> Safety procedures need review	<input type="checkbox"/> Building conditions	<input type="checkbox"/> Weather		
<input type="checkbox"/> Training needed	<input type="checkbox"/> Chemicals	<input type="checkbox"/> Caused by a 3rd party, name: _____		
<u>Employee:</u>	<input type="checkbox"/> Lighting			
<input type="checkbox"/> Excessive force (sudden onset)	<u>Equipment</u>			
<input type="checkbox"/> Overexertion (developed over time)	<input type="checkbox"/> Improper use			
<input type="checkbox"/> Repetitive motion	<input type="checkbox"/> Proper tool not available or not used			
<input type="checkbox"/> Rushing	<input type="checkbox"/> PPE needs to be reviewed			
<input type="checkbox"/> Awkward posture	<input type="checkbox"/> Tool/equipment in need of repair, describe:			
<input type="checkbox"/> Eyes not on task				
<input type="checkbox"/> Mind not on task				
<input type="checkbox"/> Balance or traction				
<input type="checkbox"/> Grip	<u>Other/Explain:</u>			
<input type="checkbox"/> Assistance was needed with task				
<input type="checkbox"/> Cellphone in use				
<input type="checkbox"/> Headphones/ earbuds in use				
<b>Recommendations:</b>				
<b>What can be done to prevent this incident or illness from happening again?</b>				
Explain: _____				
_____				
<b>Who will follow up?</b> _____ <b>Date to be completed:</b> _____				
<b>Signatures:</b> <i>By signing below, I certify that this information is true and correct to the best of my knowledge.</i>				
	Print Name	Signature	Date	Phone
Employee				
Lead Worker/ Manager				

Return this form to Safety and Risk Services **WITHIN 24 HOURS** of notice of incident or illness FAX: 855-658-7729 or email [workinjury@uoregon.edu](mailto:workinjury@uoregon.edu)