UNIVERSITY OF OREGON

WORKPLACE INJURY OR ILLNESS REPORT

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

Phone: 541-346-3192
Fax: 541-346-7008
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 or Illness ______________ Time of Incident or Illness __________ a.m. or p.m.

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 ☐ M ☐ T ☐ W ☐ T ☐ F ☐ S ☐ S Working Hours ______________

Injury Information:

Nature of Injury or Illness

☐ Burn ☐ Inflammation/irritation
☐ Bruise ☐ Scratches/abrasions
☐ Cut ☐ Sprain/strain
☐ No Injury ☐ Other ______________

Body Part Affected ______________
☐ Left ☐ Right ☐ Both

Cause of Injury or Illness

☐ Burned by: ______________
☐ Cut by: ______________
☐ Contact with: ______________
☐ Struck by: ______________

Fall/Slip/Trip	Sprain/Strain	☐ Other
☐ Different level	☐ Lifting	______________
☐ Same level	☐ Bending/squatting	______________
☐ Floor condition	☐ Holding/carrying	______________
☐ Weather condition	☐ Pushing/pulling	______________
☐ Over object	☐ Reaching	
☐ On sidewalk/path	☐ Repetitive motion	
☐ On stairs	☐ Stairs	
☐ Footwear	☐ Twisting/turning	
☐ Rushing	☐ Walking	

Treatment

☐ Received 1st aid
☐ Will be seeking medical treatment
☐ Received medical treatment
(to file a workers' compensation claim complete 801 form)
☐ Hospital transport*
☐ Fatality*
☐ No treatment
☐ Other ______________

Work Status

☐ Left work early
☐ Missed work, dates: ______________
☐ No missed work

Blood**

Was blood present? ☐ Yes ☐ No

If yes, was anyone exposed to blood? ☐ Yes** ☐ No

**If an employee was exposed to another person's blood or bodily fluids, please refer to exposure procedures at safety.uoregon.edu/bloodborne-pathogens

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

Incident Details:

Specific Site of Incident or Illness (i.e. building, room)	
Task/Activity at Time of Incident or Illness	
Witness(es) (name and contact information)	

Describe Incident or Illness
List the sequence of events; what happened and why:

____

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____

____

Root Causes:

Identify factors that may have contributed to or caused incident or illness (check all that apply):

Management
- □ Safety procedures need review
- □ Training needed

Employee:
- □ Excessive force (sudden onset)
- □ Overexertion (developed over time)
- □ Repetitive motion
- □ Rushing
- □ Awkward posture
- □ Eyes not on task
- □ Mind not on task
- □ Balance or traction
- □ Grip
- □ Assistance was needed with task
- □ Cellphone in use
- □ Headphones/ earbuds in use

Environment
- □ Building conditions
- □ Chemicals
- □ Lighting
- □ Weather
- □ Caused by a 3rd party, name: ______________________

Equipment
- □ Improper use
- □ Proper tool not available or not used
- □ PPE needs to be reviewed
- □ Tool/equipment in need of repair, describe:

____

____

Other/Explain:

____

____

____

Recommendations:

What can be done to prevent this incident or illness from happening again?

Explain: ____

____

Who will follow up? ______________________ **Date to be completed:** ______________________

Signatures: *By signing below, I certify that this information is true and correct to the best of my knowledge.*

	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: 541-346-7008 or email workinjury@uoregon.edu

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