

UNIVERSITY OF OREGON

SAFETY INCIDENT or ACCIDENT REPORT (SIAR)

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

Phone: 541-346-2907
Fax: 541-346-7008
RiskManagement@uoregon.edu

Instructions: To be completed by employee with a supervisor/manager (unclassified) **WITHIN 24 HOURS** of when employee reports a work-related accident, incident or condition. **Complete ALL sections**, do not leave any blanks.

Department _____ Date of Report _____

Date of Incident _____ Time of Incident _____ a.m. or p.m.

Employee Information:	
Employee Name _____ Last First MI	
Employee ID# _____ Birth Date _____ Position Title _____	
Employee Category <input type="checkbox"/> Regular, full-time <input type="checkbox"/> Temporary UO <input type="checkbox"/> Student Worker <input type="checkbox"/> Regular, part-time <input type="checkbox"/> Temporary Agency <input type="checkbox"/> Volunteer	
Working Days <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Working Hours _____ M T W T F S S	
Injury Information:	
<div style="border: 1px solid black; padding: 2px; margin-bottom: 5px;">Treatment</div> <input type="checkbox"/> Received 1 st aid <input type="checkbox"/> Will be seeking medical treatment <input type="checkbox"/> Received medical treatment (Workers' Compensation Form 801 must also be completed) <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-top: 5px;">Work Status</div> <input type="checkbox"/> Left work early <input type="checkbox"/> Missed work, dates: _____ <input type="checkbox"/> No missed work	<div style="border: 1px solid black; padding: 2px; margin-bottom: 5px;">Cause of Injury</div> <input type="checkbox"/> Burned by: _____ <input type="checkbox"/> Cut by: _____ <input type="checkbox"/> Contact with: _____ <input type="checkbox"/> Struck by: _____ <div style="display: flex; justify-content: space-between; font-size: small;"> <div style="width: 30%;"><u>Fall/Slip/Trip</u></div> <div style="width: 30%;"><u>Sprain/Strain</u></div> <div style="width: 30%;"><input type="checkbox"/> <u>Other</u></div> </div> <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"/> Twisting/turning <input type="checkbox"/> Walking
<div style="border: 1px solid black; padding: 2px; margin-bottom: 5px;">Nature of Injury</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"/> 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;">Blood**</div> Was blood present? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, was anyone else exposed to blood? <input type="checkbox"/> Yes <input type="checkbox"/> No How was blood cleaned up? _____
<p>*If fatality or hospital transport, call Safety and Risk Services immediately at 541-346-3192. **Any employee who was exposed to blood or other potentially infectious materials may require a medical consultation within 24 hours. Call Safety and Risk Services at 541-346-3192.</p>	

Incident Details:				
Specific Site of Incident (i.e. building, room, etc.)				
Task/Activity at Time of Incident				
Describe Incident List the sequence of events; what happened and why.				
Root Causes:				
Identify factors that may have contributed to or caused incident (check all that apply):				
<u>Management</u>	<u>Equipment</u>			
<input type="checkbox"/> Safety procedures need to be reviewed	<input type="checkbox"/> Improper use			
<input type="checkbox"/> Training needed	<input type="checkbox"/> Proper tool not available or not used			
<u>Employee</u>	<input type="checkbox"/> PPE needs to be reviewed			
<input type="checkbox"/> Attention to surroundings	<input type="checkbox"/> Tool/equipment in need of repair, describe:			
<input type="checkbox"/> Ergonomics or body mechanics	_____			

<u>Environment</u>	<u>Other/Explain:</u>			
<input type="checkbox"/> Building condition	_____			
<input type="checkbox"/> Chemicals	_____			
<input type="checkbox"/> Lighting	_____			
<input type="checkbox"/> Weather	_____			
<input type="checkbox"/> Caused by a 3 rd party	_____			
Name: _____	_____			

Recommendations:				
What can be done to prevent this incident from happening again?				
<input type="checkbox"/> Training	<input type="checkbox"/> Maintenance/repair	<input type="checkbox"/> Request assistance with task	<input type="checkbox"/> Other	
Explain: _____				

Who will follow up? _____ Date to be completed: _____				
Signatures: <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				
Supervisor				

Return this form to Safety and Risk Services **WITHIN 24 HOURS** of notice of incident
 FAX: 541-346-7008 or email RiskManagement@uoregon.edu