Department of Corrections
WASHINGTON STATE

ACCIDENT/INJURY REPORT

TO BE COMPLETED within 24 hours

This form is to be used to report workplace accidents to include: near misses, injuries, illnesses, or exposures. The individual will complete Part I of this report. The supervisor or instructor will conduct a thorough review and complete Part II. The Safety Officer will investigate the event, identify a primary cause, if possible, add any written recommendations and distribute the form when completed.

Do not move equipment involved in a work-related accident involving a death, inpatient hospitalization, amputation, or loss of an eye. The equipment must not be moved until a representative of the Department of Labor and Industries investigates the accident and releases the equipment unless moving the equipment is necessary to: a) Remove any victims or b) Prevent further incidents and injuries.

PART 1 – COMPLETE WITHIN 24 HOURS

1. ☐ Employee ☐ Contract staff ☐ Volunteer

2. Name (Last, First, MI)	3. Sex ☐ M ☐ F	4. Birthdate	5. Work phone	Ext.

6. Job classification/Working title	7. Normal scheduled shift ☐ Day ☐ Afternoon ☐ Night	8. Days off

9. Assigned work location	10. Address/Mail stop

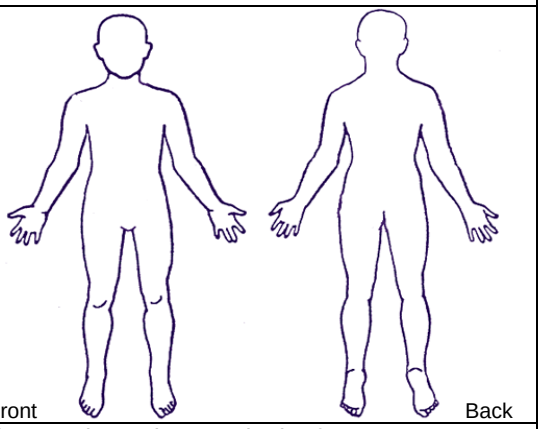
11a. Facility name	11b. Building	11c. General

12. Incident date	13. Incident time ☐ AM ☐ PM

14. What part(s) of body was affected (e.g., right ankle, left index finger, lungs)?

15. Type of injury (Check all that apply)

- ☐ No injury/illness
- ☐ Ache/Soreness
- ☐ Noise
- ☐ Burn-Chemical
- ☐ Burn-Flame
- ☐ Burn-Steam
- ☐ Dizziness
- ☐ Disease/Infection
- ☐ Tingling/Numbness
- ☐ Contusion/Bruise(s)
- ☐ Contact with toxics/chemicals
- ☐ Needle stick
- ☐ Blood/Bodily fluids
- ☐ Fumes/Gas/Vapors
- ☐ Wound/Abrasion
- ☐ Nausea
- ☐ Sprain/Strain
- ☐ Other _____



16. How did you sustain this injury?

17. What have you done or are going to do to ensure accidents/incidents of this type do not happen in the future?

18. Did this incident occur during training? ☐ Yes ☐ No	19. Do you believe you were assaulted by an offender? (Per DOC 830.180 Assault Benefits for Employees) ☐ Yes ☐ No
20. Was this a work related injury? ☐ Yes ☐ No	21. Was this an aggravation of a previous injury? ☐ Yes ☐ No

22. To whom did you report this to?	23. Name of witness, their title, and work telephone number(s)

Supervisor/Instructor name (Last, First, MI)

_____ _____

Signature Date

PART II – TO BE COMPLETED BY THE SUPERVISOR (OR INSTRUCTOR IF INJURED DURING TRAINING) WITHIN 7 DAYS

Investigation to be completed and sent to the Safety Officer within 7 days. Please use the following guide to assist in completing this section and the review process. Verify the individual's description of the accident/injury in Part I of the form. If necessary, diagram the accident/injury scene and/or take pictures, which can be attached to this section.

Determine:

- If there were any witnesses, obtain witness statements
- If other corrective action has taken place or is required
- If training is an issue and, if so, if it has been scheduled or coordinated

24. Based on your Fact Find Review, how did your employee sustain a work related injury? Identify who, what, when, where, how, and why (Be specific)

25. List actions/recommendations you have and/or will be taking to prevent future injuries of this nature.

26. Did this accident/injury occur while performing duties as an employee or working as a Class 2, 4, or 5 offender? ☐ Yes ☐ No

27. If the employee was exposed to blood and/or body fluids, have they been provided with the Blood and Bodily Fluid packet per DOC 890.600? ☐ Yes ☐ No

28. Was first aid rendered? ☐ Yes ☐ No

29. Was the individual advised to seek medical care? ☐ Yes ☐ No

30. Was the individual taken to a doctor? ☐ Yes ☐ No

31. If exposure to a toxic substance, list type of chemical, name, and manufacturer name.

32. Was equipment defective? ☐ Yes ☐ No

33. If equipment was defective, give the time and date it was removed from service.

34. Was equipment being properly used? ☐ Yes ☐ No

35. If no, why?

36. Are there records to show that the individual was trained on how to use this equipment? ☐ Yes ☐ No

37. Please attach any additional documents connected to this incident to this report.

38. Was required Personal Protective Equipment used? ☐ Yes ☐ No

39. If no, why?

40. Were proper procedures followed? ☐ Yes ☐ No

41. What was the identified hazard (e.g., needle, hole in ground, etc.)?

42. Has a work request/requisition been initiated? ☐ Yes ☐ No

43. List the work order/requisition number: _____
Work Order date: _____

Here

QUESTIONS 44 – 46 ARE FOR ASSAULTS ONLY (DOC 830.180 Assault Benefits for Employees)

44. Was this injury a result of use of force? ☐ Yes ☐ No

45. Do you believe s/he was assaulted by an offender? ☐ Yes ☐ No

46. Date employee was advised of assault benefits: / /

Supervisor/instructor name (Last, First, MI)	Supervisor/instructor title	Telephone number
Supervisor/instructor signature		Date

PART III – TO BE COMPLETED BY THE SAFETY OFFICER WITHIN 7 CALENDAR DAYS

(If delayed, an advance copy will be sent to Human Resources)

- Ensure all information is legible, filled in, and correct
- Investigate/review and identify what factors caused the incident
- Distribute form accordingly and submit to Risk Management database

What action can be taken to prevent this type of event?

Primary causative factor

Corrective Action Plan

Safety Officer name	Safety Officer signature	Date

The contents of this document may be eligible for public disclosure. Social Security Numbers are considered confidential information and will be redacted in the event of such a request. This form is governed by Executive Order 16-01, RCW 42.56, and RCW 40.14.

Distribution: **ORIGINAL** - Safety Officer **COPIES** - Human Resources, Reporter, Correctional Industries Manager (if applicable)