

Safety Incident / Near Miss Report

Please read the General Instructions / Distribution information on Page 2 prior to completing this form.

DATE OF INCIDENT	INCIDENT TYPE
TIME OF INCIDENT	<input type="checkbox"/> Near Miss
<input type="checkbox"/> AM <input type="checkbox"/> PM	<input type="checkbox"/> Injury

Part 1. To be completed by affected employee / volunteer

1. NAME (LAST, FIRST, MI)		2. GENDER <input type="checkbox"/> Male <input type="checkbox"/> Female		3. DATE OF BIRTH		4. EMPLOYEE ID NUMBER	
5. HOME MAILING ADDRESS				CITY		STATE ZIP CODE	
6. HOME TELEPHONE NUMBER ()							
7. JOB / POSITION TITLE		8. HOW LONG IN POSITION?		9. TIME WORK SHIFT BEGINS		10. WORK DAYS	
						11. DAYS OFF	
12. ASSIGNED WORK LOCATION (FACILITY / OFFICE NAME)						13. WORK TELEPHONE NUMBER ()	
14. WORK LOCATION MAILING ADDRESS				CITY		STATE ZIP CODE	
15. REGION							
16. DESCRIBE THE LOCATION WHERE THE INCIDENT OCCURRED (BLDG, ROOM, ETC.)						17. WERE YOU IN A TRAVEL STATUS? <input type="checkbox"/> Yes <input type="checkbox"/> No	

Note: Items 18–26 are for reporting injuries. If you are reporting a non-injury Near Miss incident, skip to Item 27.

18. DID THE INCIDENT RESULT IN AN IMMEDIATE PHYSICAL INJURY? <input type="checkbox"/> Yes <input type="checkbox"/> No		19. DO YOU ANTICIPATE THERE WILL BE A NEED FOR FOLLOW-UP MEDICAL ATTENTION? <input type="checkbox"/> Yes <input type="checkbox"/> No	
20. IDENTIFY YOUR PHYSICAL INJURY (ANNOTATE "1" IN THE BOX FOR THE PRIMARY INJURY, AND AN "X" FOR ANY SECONDARY INJURIES)			
<input type="checkbox"/> Cut	<input type="checkbox"/> Sever	<input type="checkbox"/> Burn	<input type="checkbox"/> Puncture
<input type="checkbox"/> Fracture	<input type="checkbox"/> Bite	<input type="checkbox"/> Bleeding	<input type="checkbox"/> Unconsciousness
<input type="checkbox"/> Abrasion / scratch	<input type="checkbox"/> Bruise	<input type="checkbox"/> Bodily reaction	<input type="checkbox"/> Dizziness
<input type="checkbox"/> Sprain / strain	<input type="checkbox"/> Swelling / redness	<input type="checkbox"/> Ache	<input type="checkbox"/> Numbness
<input type="checkbox"/> Impale	<input type="checkbox"/> Gouge	<input type="checkbox"/> Stab	<input type="checkbox"/> Pinch
<input type="checkbox"/> Shock / electrocution	<input type="checkbox"/> Asphyxiate	<input type="checkbox"/> Crush	<input type="checkbox"/> Smother
<input type="checkbox"/> Gunshot			
<input type="checkbox"/> Other (specify):		Further clarification (e.g., degree of burn, origin of bite):	
21. IDENTIFY BODY PART(S) AFFECTED (ANNOTATE "1" IN THE BOX FOR THE PRIMARY BODY PART, X FOR ANY SECONDARY PARTS)			
<input type="checkbox"/> Head	<input type="checkbox"/> Eye	<input type="checkbox"/> Shoulder	<input type="checkbox"/> Wrist
<input type="checkbox"/> Back (upper)	<input type="checkbox"/> Ribs	<input type="checkbox"/> Hip	<input type="checkbox"/> Lungs
<input type="checkbox"/> Scalp	<input type="checkbox"/> Teeth	<input type="checkbox"/> Arm (upper)	<input type="checkbox"/> Hand
<input type="checkbox"/> Back (lower)	<input type="checkbox"/> Leg (upper)	<input type="checkbox"/> Ankle	<input type="checkbox"/> Groin
<input type="checkbox"/> Face	<input type="checkbox"/> Nose	<input type="checkbox"/> Arm (lower)	<input type="checkbox"/> Finger
<input type="checkbox"/> Abdomen	<input type="checkbox"/> Leg (lower)	<input type="checkbox"/> Foot	<input type="checkbox"/> Buttocks
<input type="checkbox"/> Jaw	<input type="checkbox"/> Neck	<input type="checkbox"/> Elbow	<input type="checkbox"/> Thumb
<input type="checkbox"/> Chest	<input type="checkbox"/> Knee	<input type="checkbox"/> Toe	<input type="checkbox"/> Artificial appliance
<input type="checkbox"/> Other (specify):		Further clarification (e.g., left leg, right index finger):	
22. WHAT CAUSED THE INCIDENT (ANNOTATE IN THE BOX 1 FOR THE PRIMARY CAUSE, 2 FOR THE SECONDARY, ETC.)		23. WERE YOU PHYSICALLY EXPOSED TO:	
<input type="checkbox"/> Lifting object	<input type="checkbox"/> Lifting client	<input type="checkbox"/> Carrying object	<input type="checkbox"/> Airborne communicable disease
<input type="checkbox"/> Fall from a height	<input type="checkbox"/> Fall due to slip / trip	<input type="checkbox"/> Pushing / pulling	<input type="checkbox"/> Blood / body fluids
<input type="checkbox"/> Exposure to hot object	<input type="checkbox"/> Slip / trip, but no fall	<input type="checkbox"/> Exposure to sun / heat	<input type="checkbox"/> Chemicals:
<input type="checkbox"/> Repetitive motion	<input type="checkbox"/> Exposure to cold object	<input type="checkbox"/> Motor vehicle accident	<input type="checkbox"/> Fumes / gases
<input type="checkbox"/> Caught in / between / under	<input type="checkbox"/> Bitten	<input type="checkbox"/> Participation in training	<input type="checkbox"/> Corrosive / toxic liquids
<input type="checkbox"/> Needle stick			<input type="checkbox"/> Corrosive / toxic solids
<input type="checkbox"/> Struck. Describe what struck by:			<input type="checkbox"/> Other (specify):
<input type="checkbox"/> Grabbed. Describe what grabbed by:			<input type="checkbox"/> None
<input type="checkbox"/> Cut. Describe what cut by:			
<input type="checkbox"/> Other (specify):			
Further Clarification (e.g., car passenger, fall on ice):		24. METHOD OF EXPOSURE:	
		<input type="checkbox"/> Absorption <input type="checkbox"/> Ingestion	
		<input type="checkbox"/> Injection <input type="checkbox"/> Inhalation	
		Note: If exposure occurred, please complete a DSHS form 03-333 and attach.	

25. Did the incident involve direct physical contact with a hostile, aggressive, or out-of-control client?		YES	NO
		<input type="checkbox"/>	<input type="checkbox"/>
If yes, did the unwanted touching result in any physical injury?		<input type="checkbox"/>	<input type="checkbox"/>
If you answered "YES" to both questions and consider this incident an assault, please complete a Report of Possible Client Assault, DSHS 03-391 and attach. Note: Applies only to staff specifically identified in RCW 72.01.045 or RCW 74.04.790).			

26. CLIENT NUMBER	Caution: Other than a client identification number, please do not cite the name, other personal identifiable information, or any health-related information regarding any client on this form or on attached documents.
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27. FULLY DESCRIBE WHAT DUTIES YOU WERE PERFORMING IMMEDIATELY PRECEDING THE INCIDENT (ATTACH ADDITIONAL PAGE(S) AS NECESSARY)			
28. PROVIDE A DETAILED DESCRIPTION OF THE INCIDENT (ATTACH ADDITIONAL PAGE(S) AS NECESSARY)			
29. DESCRIBE THE ACTIONS, EVENTS OR CONDITIONS WHICH MAY HAVE CONTRIBUTED TO THE INCIDENT (ATTACH ADDITIONAL PAGE(S) AS NECESSARY)			
30. EMPLOYEE'S RECOMMENDATIONS TO PREVENT A REOCCURRENCE OF SIMILAR INCIDENTS			
31. NAME OF EYEWITNESS(ES) TO THE INCIDENT (ATTACH ADDITIONAL PAGE(S) AS NECESSARY)		PHONE NUMBER	
1.		()	
2.		()	
3.		()	
32. TO WHOM DID YOU FIRST REPORT THIS INCIDENT?			
NAME	PHONE NUMBER ()	DATE	TIME <input type="checkbox"/> AM <input type="checkbox"/> PM
33. EMPLOYEE / VOLUNTEER'S NAME, OR THE NAME OF PERSON COMPLETING THIS FORM (PLEASE PRINT)		MAIL STOP	WORK PHONE NUMBER ()
34. EMPLOYEE / VOLUNTEER'S SIGNATURE, OR SIGNATURE OF PERSON COMPLETING THIS FORM		DATE	NOTE: Upon receipt of this report, the supervisor / manager must conduct an immediate preliminary investigation, and complete and submit DSHS form 03-133A, Supervisor's Review of Injury / Illness Incident.

FOR QUESTIONS: Call the Claims Management Section at 1-866-712-3890, or consult the Claims Section website at: <http://one.dshs.wa.lcl/FS/Loss/WorkersComp/Pages/default.aspx>

General Instructions / Distribution

For purposes of this form, a "Near Miss" incident is any event that could have resulted in an on-the-job employee injury or death, but fortunately did not. Reporting of "Near Miss" events enables the Department to use the information to help prevent future incidents and the possibility of future injuries.

This document should be completed by the affected, injured / ill individual within one (1) business day of the incident or their awareness of their injury / illness.

- Answer all questions as completely as possible. Incomplete forms will be returned for additional information and may delay payment of qualified benefits.
- Be sure to include the affected or injured / ill individual's name and date of the incident on any sheets required to be attached.
- Sign and date the form, and submit all documents to the affected or injured / ill employee's supervisor /manager. Copies should be forwarded to the local safety office and retained in local files for six years.

If the affected or injured / ill person is unavailable to complete and submit this document within one (1) business day, a supervisor or other designated person should complete the form as thoroughly as possible. Sign in the signature block (Block 29) and add the statement, "Completed for unavailable employee / volunteer."