

Work Related Illness / Injury Supervisor Report



King County

Human Resources Division
Safety and Claims Management
 ADM-ES-0500
 500 Fourth Avenue, Suite 500
 Seattle, WA 98104
206-477-3350 Fax 206-296-0514

Employee Name		Home Address			Home Phone	
Date of Birth	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Marital Status <input type="checkbox"/> Married <input type="checkbox"/> Not Married		Job Title		
Department / Division		Work Phone		Workshift from _____ to _____ (hours)	Days Per Week _____	Regular Days Off _____
Work Location		Supervisor / Chief Name			Supervisor / Chief's Phone #	
Employment Category <input type="checkbox"/> Temporary <input type="checkbox"/> Seasonal <input type="checkbox"/> Regular, full-time <input type="checkbox"/> Regular, part-time		ID #	Org #	SIF-2 Claim #		
Mail Stop	Did accident or exposure occur on King County premises? <input type="checkbox"/> Yes <input type="checkbox"/> No		Location		Date Reported	Date of Occurrence
Time <input type="checkbox"/> a.m. <input type="checkbox"/> p.m.	Shift <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3	Doctor / Hospital, Address, Phone #			Eyewitness	
Did injury cause loss of time (other than on day of injury?) <input type="checkbox"/> Yes <input type="checkbox"/> No		If yes, date last worked _____		If known, date returned to work _____	Time lost from work on day of injury _____ hours	
Will this injury restrict employee's normal job duties? <input type="checkbox"/> Yes <input type="checkbox"/> No				If the employee's job duties are restricted, for approximately how many days? _____		
Police report filed? <input type="checkbox"/> Yes <input type="checkbox"/> No	Do you have light duty available? If so, describe _____					
Transit Only	Coach #	Route #	Run #	Coach Type: <input type="checkbox"/> Trolley <input type="checkbox"/> Motor Coach <input type="checkbox"/> Streetcar <input type="checkbox"/> Van		

Check one item in each of the following three categories:

Part of the Body			
<input type="checkbox"/> Abdomen	<input type="checkbox"/> Eye: <input type="checkbox"/> L <input type="checkbox"/> R	<input type="checkbox"/> Hand: <input type="checkbox"/> L <input type="checkbox"/> R	<input type="checkbox"/> Mental
<input type="checkbox"/> Ankle: <input type="checkbox"/> L <input type="checkbox"/> R	<input type="checkbox"/> Face	<input type="checkbox"/> Head	<input type="checkbox"/> Mouth
<input type="checkbox"/> Arm: <input type="checkbox"/> L <input type="checkbox"/> R	<input type="checkbox"/> Finger: <input type="checkbox"/> Index	<input type="checkbox"/> Heart	<input type="checkbox"/> Multiple – Describe in A _____
<input type="checkbox"/> Back: <input type="checkbox"/> Low <input type="checkbox"/> Upper	<input type="checkbox"/> Middle <input type="checkbox"/> Ring	<input type="checkbox"/> Heel: <input type="checkbox"/> L <input type="checkbox"/> R	<input type="checkbox"/> Neck
<input type="checkbox"/> Buttocks	<input type="checkbox"/> Little	<input type="checkbox"/> Hip: <input type="checkbox"/> L <input type="checkbox"/> R	<input type="checkbox"/> Nose
<input type="checkbox"/> Chest	<input type="checkbox"/> Foot: <input type="checkbox"/> L <input type="checkbox"/> R	<input type="checkbox"/> Internal	<input type="checkbox"/> Pelvis
<input type="checkbox"/> Chin	<input type="checkbox"/> Forearm: <input type="checkbox"/> L <input type="checkbox"/> R	<input type="checkbox"/> Jaw	<input type="checkbox"/> Respiratory – Upper
<input type="checkbox"/> Ears: <input type="checkbox"/> L <input type="checkbox"/> R	<input type="checkbox"/> Forehead	<input type="checkbox"/> Knee: <input type="checkbox"/> L <input type="checkbox"/> R	<input type="checkbox"/> Rib
<input type="checkbox"/> Elbow: <input type="checkbox"/> L <input type="checkbox"/> R	<input type="checkbox"/> Glasses	<input type="checkbox"/> Leg: <input type="checkbox"/> L <input type="checkbox"/> R	<input type="checkbox"/> Scalp
	<input type="checkbox"/> Groin	<input type="checkbox"/> Lung	<input type="checkbox"/> Shoulder: <input type="checkbox"/> L <input type="checkbox"/> R
			<input type="checkbox"/> Stomach
			<input type="checkbox"/> Teeth
			<input type="checkbox"/> Thumb: <input type="checkbox"/> L <input type="checkbox"/> R
			<input type="checkbox"/> Toe <input type="checkbox"/> Toes
			<input type="checkbox"/> Wrist: <input type="checkbox"/> L <input type="checkbox"/> R
			<input type="checkbox"/> Other – Describe in A _____
			<input type="checkbox"/> _____
			<input type="checkbox"/> _____
			<input type="checkbox"/> _____
			<input type="checkbox"/> _____
Accident Type			
<input type="checkbox"/> Altercation	<input type="checkbox"/> Electric shock	<input type="checkbox"/> Kneeling	<input type="checkbox"/> Slipped, did not fall
<input type="checkbox"/> Animal / Insect	<input type="checkbox"/> Explosion	<input type="checkbox"/> Lack of oxygen	<input type="checkbox"/> Standing
<input type="checkbox"/> Assault: <input type="checkbox"/> Physical	<input type="checkbox"/> Extreme temperature	<input type="checkbox"/> Lifting	<input type="checkbox"/> Stepped in / on or off
<input type="checkbox"/> Verbal	<input type="checkbox"/> Fall from different level	<input type="checkbox"/> Motor vehicle accident	<input type="checkbox"/> Stretched
<input type="checkbox"/> Bending	<input type="checkbox"/> Fall from ladder	<input type="checkbox"/> Noise	<input type="checkbox"/> Struck against fixed object
<input type="checkbox"/> Bicycle	<input type="checkbox"/> Fall from liquid or grease spill	<input type="checkbox"/> Object handled	<input type="checkbox"/> Struck by moving object
<input type="checkbox"/> Carrying	<input type="checkbox"/> Fall from same level	<input type="checkbox"/> Observation	<input type="checkbox"/> Struck by falling object
<input type="checkbox"/> Caught	<input type="checkbox"/> Fall from stairs	<input type="checkbox"/> Over exertion	<input type="checkbox"/> Struck by flying object
<input type="checkbox"/> Caught by fixed object	<input type="checkbox"/> Foreign body	<input type="checkbox"/> Pulling	<input type="checkbox"/> Throwing
<input type="checkbox"/> Caught in or between	<input type="checkbox"/> Gunfire	<input type="checkbox"/> Pushing	<input type="checkbox"/> Training exercise
<input type="checkbox"/> Caught under	<input type="checkbox"/> Gripping	<input type="checkbox"/> Power tool	<input type="checkbox"/> Tripped, did not fall
<input type="checkbox"/> Climbing	<input type="checkbox"/> Hand tool	<input type="checkbox"/> Reaching	<input type="checkbox"/> Tugging
<input type="checkbox"/> Contact w/chemical	<input type="checkbox"/> Horseplay	<input type="checkbox"/> Recreation	<input type="checkbox"/> Twisted
<input type="checkbox"/> Contact w/fire or flame	<input type="checkbox"/> Inhalation	<input type="checkbox"/> Repetitive motion	<input type="checkbox"/> Vibration
<input type="checkbox"/> Contact w/hot object	<input type="checkbox"/> Ingestion	<input type="checkbox"/> Rubbed	<input type="checkbox"/> Walking
<input type="checkbox"/> Contact w/steam or hot fluid	<input type="checkbox"/> Jarring / bouncing	<input type="checkbox"/> Running	<input type="checkbox"/> Workplace environment
<input type="checkbox"/> Driving	<input type="checkbox"/> Jumping	<input type="checkbox"/> Shoveling	<input type="checkbox"/> Other – Describe in B _____
		<input type="checkbox"/> Sitting	<input type="checkbox"/> _____

Accident Type: Transit Specific

- | | | | |
|---|---|---|--|
| <input type="checkbox"/> Adjusting Mirror | <input type="checkbox"/> Entering / leaving coach | <input type="checkbox"/> Overexertion driving | <input type="checkbox"/> Struck by passenger |
| <input type="checkbox"/> Coach – Object accident | <input type="checkbox"/> Fall from bumper | <input type="checkbox"/> Pulling poles | <input type="checkbox"/> Wheelchair lift |
| <input type="checkbox"/> Coach – Vehicle accident | <input type="checkbox"/> Fall from coach step | <input type="checkbox"/> Steering coach | <input type="checkbox"/> Other _____ |

Source of Injury

- | | | | |
|---|---|--|---|
| <input type="checkbox"/> Bodily motion | <input type="checkbox"/> Electrical | <input type="checkbox"/> Stairs / ladder | <input type="checkbox"/> Unknown |
| <input type="checkbox"/> Building | <input type="checkbox"/> Machine | <input type="checkbox"/> Tool | <input type="checkbox"/> Other (Describe specific source in Section B: name of chemical, tool, machine, material, etc.) |
| <input type="checkbox"/> Chemical (Attach MSDS) | <input type="checkbox"/> Material handled | <input type="checkbox"/> Walking surface | |
| | <input type="checkbox"/> Motor vehicle | <input type="checkbox"/> Work surface | |

Immediate Accident Causes Check as many items as necessary in this category

Actions

- Bypassing safety devices
- Distraction, inattention
- Failure to secure or warn
- Failure to use protective equipment
- Failure to wear proper attire
- Horseplay
- Improper use of body
- Improper use of equipment, tools
- Inadequate maintenance

- Incorrect lifting, carrying
- Operating at unsafe speeds
- Operating without authority
- Poor housekeeping
- Taking unsafe position
- Unstable loading, stacking
- Using defective equipment, tools
- Working on live equipment
- Other – Describe in section C

Conditions

- Arrangements
- Congestion
- Design, construction
- Guarding
- Illumination
- Tools
- Traffic
- Ventilation
- Other – Describe in Section C

A. Description of Injury/Illness/Body Parts Injured (Do not include diagnosis or confidential medical information)

B. What was the employee doing (Be specific. Identify tools, equipment or material, describe activities.)

C. How did the accident occur? (Describe fully the events leading to the injury or illness. What happened and how did it happen? Name objects or substances and tell how they were involved. Give full details on all factors that led or contributed to the accident.) (For Contaminated Sharps Injuries, include type and brand of device involved and where incident occurred.)

Management Action: (Check as many items as necessary. If action is pending, document below. Include target date.)

- | | | |
|--|---|---|
| <input type="checkbox"/> Initiate, revise, enforce safe work practices | <input type="checkbox"/> Install, replace, adjust guards | <input type="checkbox"/> Provide/monitor protective equipment |
| <input type="checkbox"/> Management, revise written Process/SOP | <input type="checkbox"/> Institute job hazard/ergo analysis | <input type="checkbox"/> Provide special communications |
| <input type="checkbox"/> Improve emergency/medical system | <input type="checkbox"/> Modify, replace tools, equipment | <input type="checkbox"/> Review via task force, consultant |
| <input type="checkbox"/> Improve housekeeping, maintenance | <input type="checkbox"/> Provide inspections, observations | <input type="checkbox"/> Revise equipment, layout |
| <input type="checkbox"/> Improve job orientation, training | <input type="checkbox"/> Provide proper employee placement | <input type="checkbox"/> Other (specify) |

Transit Only:

- | | | | | |
|--|---|---|--|----------------------------------|
| <input type="checkbox"/> Collision w/vehicle | <input type="checkbox"/> Collision w/people | <input type="checkbox"/> Parking facility | <input type="checkbox"/> On right-of-way | <input type="checkbox"/> Station |
| <input type="checkbox"/> Collision w/objects | <input type="checkbox"/> Derailments off road buses | <input type="checkbox"/> Inside vehicle | <input type="checkbox"/> Egress | <input type="checkbox"/> Fire |

Signature of Immediate Supervisor _____ Date _____ Phone (_____)_____

Signature of Manager _____ Date _____ Phone (_____)_____

Send to: Safety and Claims Management, ADM-ES-0500

Transit Only Copies to: Transit Safety, SAT-TR-0110, Base Safety Officer, Base File.