



Employee / Volunteer Personal Incident Report

DATE OF INCIDENT

TIME OF INCIDENT

 AM
 PM**PART 1. TO BE COMPLETED BY EMPLOYEE / VOLUNTEER**

| | | | | | |
|--|--|---|-------|--|--------------|
| 1. NAME (PLEASE PRINT) LAST, FIRST, MI | | 2. DATE OF BIRTH | | 3. EMPLOYEE'S IDENTIFICATION NUMBER | |
| 4. MAILING ADDRESS | | CITY | STATE | ZIP CODE | |
| 5. HOME TELEPHONE NUMBER () | | 6. JOB/POSITION TITLE | | 7. SHIFT HOURS | 8. WORK DAYS |
| 9. DAYS OFF | | 10. ASSIGNED WORK LOCATION (FACILITY/OFFICE NAME AND ADDRESS) | | 11. REGION | |
| 12. EXACT LOCATION OF INCIDENT (BLDG, ROOM, ETC.) | | 13. IN TRAVEL STATUS? <input type="checkbox"/> Yes <input type="checkbox"/> No | | 14. CAUSE OF ACCIDENT (CHECK ONE) | |
| <input type="checkbox"/> Injured by client <input type="checkbox"/> Lifting client <input type="checkbox"/> Lifting object <input type="checkbox"/> Carrying <input type="checkbox"/> Push/pull <input type="checkbox"/> Fall | | <input type="checkbox"/> Caught between/under <input type="checkbox"/> Slip/trip <input type="checkbox"/> Repetitive motion <input type="checkbox"/> Contact heat/cold <input type="checkbox"/> Motor vehicle accident <input type="checkbox"/> Other (specify): | | <input type="checkbox"/> Injured in training session <input type="checkbox"/> Struck by <input type="checkbox"/> Bitten (animal, insect) <input type="checkbox"/> Cut by <input type="checkbox"/> Needle stick | |
| 15. OCCUPATIONAL EXPOSURE | | <input type="checkbox"/> Blood/body fluids <input type="checkbox"/> Airborne diseases <input type="checkbox"/> Fumes/gas <input type="checkbox"/> Chemicals <input type="checkbox"/> Other (please specify): | | | |
| 16. RESULTING INJURY (CHECK ALL THAT APPLY) | | | | | |
| <input type="checkbox"/> Cut <input type="checkbox"/> Fracture <input type="checkbox"/> Abrasion/scratch <input type="checkbox"/> Sprain/strain <input type="checkbox"/> Other (specify): | | <input type="checkbox"/> Burn <input type="checkbox"/> Bite <input type="checkbox"/> Bruise <input type="checkbox"/> Swelling/redness | | <input type="checkbox"/> Puncture <input type="checkbox"/> Bleeding <input type="checkbox"/> Bodily reaction <input type="checkbox"/> Musculoskeletal disorder (i.e., carpal tunnel, tendonitis, etc.) | |
| <input type="checkbox"/> No known injury occurred | | | | | |
| 17. BODY PART AFFECTED (CHECK ALL THAT APPLY) | | | | | |
| <input type="checkbox"/> Head <input type="checkbox"/> Scalp <input type="checkbox"/> Face <input type="checkbox"/> Jaw <input type="checkbox"/> Other (specify): | | <input type="checkbox"/> Eye <input type="checkbox"/> Teeth <input type="checkbox"/> Nose <input type="checkbox"/> Neck | | <input type="checkbox"/> Shoulder <input type="checkbox"/> Arm (upper) <input type="checkbox"/> Arm (lower) <input type="checkbox"/> Elbow | |
| <input type="checkbox"/> Wrist <input type="checkbox"/> Hand <input type="checkbox"/> Finger <input type="checkbox"/> Thumb | | <input type="checkbox"/> Back (upper) <input type="checkbox"/> Back (lower) <input type="checkbox"/> Abdomen <input type="checkbox"/> Chest | | <input type="checkbox"/> Ribs <input type="checkbox"/> Leg (upper) <input type="checkbox"/> Leg (lower) <input type="checkbox"/> Knee | |
| <input type="checkbox"/> Hip <input type="checkbox"/> Ankle <input type="checkbox"/> Foot <input type="checkbox"/> Toe | | <input type="checkbox"/> Respiratory tract <input type="checkbox"/> Groin <input type="checkbox"/> Glasses <input type="checkbox"/> Artificial appliances | | | |
| 18. DETAILED DESCRIPTION OF HOW INCIDENT OCCURRED (ATTACH ADDITIONAL PAGE(S) IF NECESSARY) | | | | | |
| 19. ACTIONS, EVENTS OR CONDITIONS WHICH CONTRIBUTED TO THE INCIDENT (ATTACH ADDITIONAL PAGE(S) IF NECESSARY) | | | | | |
| 20. RECOMMENDATIONS FOR PREVENTION AND FOLLOW-UP. (ATTACH ADDITIONAL PAGE(S) IF NECESSARY) | | | | | |
| 21. TO WHOM DID YOU REPORT THE INCIDENT? | | | | | |
| NAME | | PHONE NUMBER () | | DATE TIME | |
| | | | | <input type="checkbox"/> AM <input type="checkbox"/> PM | |
| 22. Do you believe this incident was caused by a client assault? <input type="checkbox"/> Yes <input type="checkbox"/> No Additional forms are needed if answered YES. | | | | | |
| Witness Statement, DSHS 03-389 Assault Benefits Program Witness Statement, DSHS 03-389A Employee Report of Resident/Client Assault (RCW 72.01.045, RCW 74.04.790), DSHS 03-391 Supervisor's Review of Employee Report of Resident/Client Assault, DSHS 03-394 | | | | | |
| 23. NAME OF WITNESS(ES) (ATTACH ADDITIONAL PAGE(S) IF NECESSARY) | | | | PHONE NUMBER () | |
| 24. EMPLOYEE/VOLUNTEER'S SIGNATURE | | DATE | | MAIL STOP WORK PHONE NUMBER () | |

INSTRUCTIONS

GENERAL INSTRUCTIONS:

Part 1 - To be completed by employee/volunteer. Answer all questions as completely as possible. Be sure to include your name and the date of the incident on any additional sheets. Sign and date the form, then submit all copies to your supervisor.

Part 2 - To be completed by the supervisor. Interview witnesses and thoroughly investigate the incident immediately upon notification. Answer all questions as completely as possible. In Part II, Question 6, "client" refers to any client of DSHS. If Part 1, Question 22 is "Yes," ensure additional assault addendums are completed prior to forwarding to the safety representative. Be sure to include the employee's name and date of the incident on any additional pages. Sign and date the form and forward it to the safety office or your unit safety representative (person assigned/performing safety related functions).

Part 3 - To be completed by the safety officer or unit safety representative. Review the information for completeness. Determine how extensive an investigation or review should be conducted and follow local procedures to conduct an investigation or review of the events resulting in the incident. Sign and date form. If in Part I, Question 22, is answered YES, then submit to the facility/office senior administrator or designee for recommendation. If in Part I, Question 22, is answered NO, then forward copies of form to address located below.

Part 4 - To be completed by superintendent/administrator or designated representative. If the employee answered YES to Part 1 Question 22, please review the incident and all documentation in addition to the appropriate RCW (71.01.045 or 74.04.XXX). Complete Part 4 and provide a recommendation as to approval or disapproval of a request for reimbursement under the RCW and have copies of the completed forms then forward copies to the address below.

Part 5 If the incident had any of the following occur or is anticipated that any of the following might occur an Employee Representative such as a Shop Steward or designated individual must be involved in the preliminary investigation in accordance with WAC 296-800-32020 and complete PART 5 at the bottom of page 2 of the DSHS 3-133.

- medical treatment beyond first aid
- loss of work days
- restricted work
- transfer to another job
- loss of consciousness
- death

DISTRIBUTION: DSHS institutions must forward the original DSHS 03-133 with all attachments to the local safety office.

DSHS Headquarters and Field Offices will forward the original (keep copy) DSHS 03-133 with all attachments to:

Office of Safety and Risk Management

PO Box 45882

Mail Stop: 45882

Olympia WA 98504-5882

FOR QUESTIONS: Call the Office of Safety and Risk Management at (360) 725-5833.

Web site: <http://exec.dshs.wa.lcl/safety/default.shtm>

If the employee SUBMITS a Department of Labor and Industries (L&I) "Report of Industrial Injury or Occupational Disease," forward the original DSHS 03-133 with all attachments, and the original L&I report, to the address above. You must retain copies of all forms for the L&I file kept on site.

If the employee DOES NOT SUBMIT a Department of Labor & Industries (L&I) "Report of Industrial Injury or Occupational Disease" the local Safety Office or safety representative must retain a copy of DSHS 03-133 for a minimum of six (6) years. The original report (DSHS 03-133) needs to be forwarded to the above address.

Whether the L&I report is submitted or not, distribute additional copies of the completed DSHS 03-133 to:

Safety Committee or Safety Representative (for local review procedures)

Supervisor

Employee