SAFETY INCIDENT / NEAR MISS REPORT  
DSHS 03-333 (REV. 08/2017)  

Part 1. To be completed by affected employee / volunteer  

<table>
<thead>
<tr>
<th>1. NAME (LAST, FIRST, MI)</th>
<th>2. GENDER</th>
<th>3. DATE OF BIRTH</th>
<th>4. EMPLOYEE ID NUMBER</th>
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<tr>
<td></td>
<td>Male</td>
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<td>Female</td>
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<tr>
<th>5. HOME MAILING ADDRESS</th>
<th>CITY</th>
<th>STATE</th>
<th>ZIP CODE</th>
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12. ASSIGNED WORK LOCATION (FACILITY / OFFICE NAME)  

14. WORK LOCATION MAILING ADDRESS  

16. DESCRIBE THE LOCATION WHERE THE INCIDENT OCCURRED (BLDG, ROOM, ETC.)  

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?  
19. DO YOU ANTICIPATE THERE WILL BE A NEED FOR FOLLOW-UP MEDICAL ATTENTION?  

20. IDENTIFY YOUR PHYSICAL INJURY (ANNOTATE “I” IN THE BOX FOR THE PRIMARY INJURY, AND AN “X” FOR ANY SECONDARY INJURIES)  

21. IDENTIFY BODY PART(S) AFFECTED (ANNOTATE “I” IN THE BOX FOR THE PRIMARY BODY PART, “X” FOR ANY SECONDARY PARTS)  

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:  

24. METHOD OF EXPOSURE:  

Note: If exposure occurred, please complete a DSHS form 03-333 and attach.  

25. Do you feel this incident was a result of unauthorized touching by a resident, client, patient, or juvenile offender?  
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Caution: Other than a client identification number, please do not cite the name, other personal identifiable information, or any health-related information regarding any client on this form or on attached documents.
### SAFETY INCIDENT / NEAR MISS REPORT

**DSHS 03-133 (REV. 08/2017)**

1. **FULLY DESCRIBE WHAT DUTIES YOU WERE PERFORMING IMMEDIATELY PRECEDING THE INCIDENT (ATTACH ADDITIONAL PAGE(S) AS NECESSARY)**

2. **PROVIDE A DETAILED DESCRIPTION OF THE INCIDENT (ATTACH ADDITIONAL PAGE(S) AS NECESSARY)**

3. **DESCRIBE THE ACTIONS, EVENTS OR CONDITIONS WHICH MAY HAVE CONTRIBUTED TO THE INCIDENT (ATTACH ADDITIONAL PAGE(S) AS NECESSARY)**

4. **EMPLOYEE’S RECOMMENDATIONS TO PREVENT A REOCURRENCE OF SIMILAR INCIDENTS**

5. **NAME OF EYEWITNESS(ES) TO THE INCIDENT (ATTACH ADDITIONAL PAGE(S) AS NECESSARY)**

<table>
<thead>
<tr>
<th>Name</th>
<th>Phone Number</th>
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6. **TO WHOM DID YOU FIRST REPORT THIS INCIDENT?**

<table>
<thead>
<tr>
<th>Name</th>
<th>Phone Number</th>
<th>Date</th>
<th>Time</th>
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<td>□ AM □ PM</td>
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7. **EMPLOYEE / VOLUNTEER’S NAME, OR THE NAME OF PERSON COMPLETING THIS FORM**

   **MAIL STOP**

   **WORK PHONE NUMBER**

   ( )

8. **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 Safety Incident / Near Miss Report.

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**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](http://one.dshs.wa.lcl/FS/Loss/WorkersComp/Pages/default.aspx)

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**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 34) and add the statement, “Completed for unavailable employee / volunteer.”