Washington State Department of Social & Health Services
Transforming lives

Work Related Injury / Close Call Report

Please read the General Instructions / Distribution information on Page 4 prior to completing this form.

DATE OF INCIDENT

TIME OF INCIDENT ☐ AM ☐ PM

Part 1. To be completed by employee / volunteer

1. NAME (FIRST, MIDDLE INITIAL, LAST)
2. GENDER ☐ Male ☐ 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 CURRENT POSITION? ☐ 0 – 3 mos. ☐ 4 – 6 mos. ☐ 7 – 11 mos. ☐ 1 – 3 yrs. ☐ 4+ yrs.
9. SHIFT WORKED ☐ Day ☐ Swing ☐ Night
10. CHECK WHICH DAYS OF THE WEEK EMPLOYEE / VOLUNTEER WORKS ☐ Mon ☐ Tues ☐ Wed ☐ Thurs ☐ Fri ☐ Sat ☐ Sun ☐ on call
11. EMPLOYMENT STATUS OF THE EMPLOYEE / VOLUNTEER ☐ Permanent / Full-time ☐ Permanent / Part-time ☐ Non-permanent ☐ On-call ☐ Volunteer ☐ Non-DSHS Employee ☐ Contractor ☐ **Other**
12. ASSIGNED WORK LOCATION (FACILITY / OFFICE NAME)
13. WORK LOCATION MAILING ADDRESS CITY STATE ZIP CODE
14. IDENTIFY THE PRECISE LOCATION WHERE THE INCIDENT OCCURRED
    FACILITY | BUILDING | ROOM | FURTHER DESCRIPTION OF LOCATION

Note: If you are reporting a Close Call incident, skip to Item 18. A "close call" is any event that did not result in injury, illness or damage –but could have if the circumstances had been slightly different.

15. IDENTIFY THE EMPLOYEE / VOLUNTEER'S REPORTED CONDITION
    ☐ Abrasion / scratch ☐ Bite (human open) ☐ Cut ☐ Shock / electrocution
    ☐ Ache ☐ Bruise ☐ Dizziness ☐ Sprain / strain
    ☐ Allergic reaction ☐ Burn ☐ Numbness ☐ Swelling / redness
    ☐ Bite (animal / insect) ☐ Crush / pinch ☐ Puncture ☐ Unconsciousness
    ☐ Bite (human closed) ☐ Other (specify):
    Further clarification (e.g., degree of burn, origin of bite):
16. REPORTED BODY PART(S) AFFECTED
    ☐ Abdomen ☐ Back (upper) ☐ Ear ☐ Glasses ☐ Jaw ☐ Neck ☐ Teeth
    ☐ Ankle ☐ Back (lower) ☐ Eye ☐ Groin ☐ Knee ☐ Nose ☐ Thumb
    ☐ Arm (upper) ☐ Buttocks ☐ Face ☐ Hand ☐ Leg (upper) ☐ Ribs ☐ Toe
    ☐ Arm (lower) ☐ Chest ☐ Finger ☐ Head ☐ Leg (lower) ☐ Scalp ☐ Wrist
    ☐ Artificial appliance ☐ Elbow ☐ Foot ☐ Hip ☐ Lungs ☐ Shoulder
    ☐ Other (specify):
    Further clarification (e.g., left leg, right index finger):
17. WHAT CAUSED THE REPORTED CONDITION
    ☐ Bitten ☐ Contact to hot / cold object ☐ Lifting object ☐ Pushing / pulling
    ☐ Carrying object ☐ Fall due to slip / trip ☐ Motor vehicle accident ☐ Repetitive motion
    ☐ Caught in / between / under ☐ Fall from a height ☐ Needle stick ☐ Slip / trip no fall
    ☐ Choke / strangle ☐ Lifting client ☐ Participation in training
    ☐ Struck. Describe what struck by:
    ☐ Grabbed. Describe what grabbed by:
    ☐ Cut. Describe what cut by:
    ☐ Other (specify):
    Further Clarification (e.g., car passenger, fall on ice):
    Exposure to: ☐ Sun / heat ☐ Chemicals ☐ Loud Noise ☐ Contaminants
    Exposure to: ☐ Bodily fluids ☐ Diseases ☐ Pathogens

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

18. PROVIDE A DETAILED DESCRIPTION, STEP BY STEP, OF HOW THE INCIDENT, OCCURRED (ATTACH ADDITIONAL PAGE(S) AS NEEDED)

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

20. WHAT COULD HAVE BEEN DONE TO PREVENT THIS INCIDENT

21. CLIENT NUMBER **(IF A CLIENT WAS INVOLVED)**	**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.**

22. Do you feel this incident was a result of unauthorized touching by a resident, client, or patient? ☐ Yes ☐ No

Did the unauthorized touching by a resident, client, or patient resulted in a physical injury? ☐ Yes ☐ No

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).

23. NAME OF EYEWITNESS(ES) TO THE INCIDENT (ATTACH ADDITIONAL PAGE(S) AS NECESSARY)	PHONE NUMBER
1.	( )
2.	( )
3.	( )

24. TO WHOM DID YOU FIRST REPORT THIS INCIDENT?

NAME | PHONE NUMBER ( ) | DATE

25. EMPLOYEE / VOLUNTEER'S NAME, OR THE NAME OF PERSON COMPLETING THIS FORM

SIGNATURE | DATE | PRINTED NAME

Give this report to your supervisor.

NOTE: Upon receipt of this report, the supervisor / manager must conduct an immediate preliminary investigation, and complete Part 2 below.

Part 2. Completed by Supervisor / Manager

Review of incident by supervisor / manager. Please complete the form in its entirety.

	YES	NO
1. What was the date that this incident was first reported to you?		
2. Was the hazard that caused the condition identified in the Job Hazard Assessment?	☐	☐
3. Was the employee / volunteer made aware of the safety and occupational health hazards associated with their duties / responsibilities?	☐	☐
4. Was the employee / volunteer engaged in their regular duties when the incident occurred?	☐	☐

	YES	NO
5. Was the employee / volunteer working overtime when the incident occurred?	☐	☐
a. If yes, how many hours straight had the employee been working? _____		
b. How many overtime shifts had the employee worked in the seven (7) days prior to the incident? _____		
6. Was hospitalization provided / sought for the employee following the incident?	☐	☐
Note: For serious incidents, an Employee Representative must be identified to assist in this review. Serious incidents may include: employee death, unconsciousness, days away from work, amputations, and loss of one or both eyes (see Part 3 below).		
7. If the employee / volunteer has missed time from work due to this incident, what date did they last work? _____		
8. Were there current DSHS, Administration, Division, Region, Facility, or other local policies or standard operating procedures governing the activities being performed by the employee / volunteer at the time of the incident?	☐	☐
a. If yes, were the appropriate policies or standards being followed?	☐	☐
b. If policies / standards were required to be followed, but were not in this circumstance, please explain why not.		
9. Did you conclude the incident to be the result of an unsafe physical WORK ENVIRONMENT?	☐	☐
a. If yes, please describe the specific safety / health hazard(s) that contributed and any actions you have taken to correct the safety or health hazards:		
10. Did you conclude the incident was the result of an unsafe WORK PRACTICE or PROCEDURE (e.g., improper use of PPE, lifting assistance / equipment, etc.)?	☐	☐
a. If yes, please describe the unsafe work practice / procedure and any actions you have taken to correct the unsafe work practice:		
11. To help prevent future reoccurrences, did you discuss the incident and corrective actions with the employee / volunteer and the remainder of your staff?	☐	☐
a. What other actions have you taken to prevent a reoccurrence of similar incidents?		
12. Based on your review, does this incident require further investigation?	☐	☐

13. SUPERVISOR'S NAME (PLEASE PRINT)	14. WORK PHONE NUMBER ( )
15. SUPERVISOR'S SIGNATURE	DATE

Part 3. Employee representative review (shop steward or designated individual) per WAC 296-800-32020

1. EMPLOYEE REPRESENTATIVE'S NAME (PLEASE PRINT)	2. TELEPHONE NUMBER ( )
3. REPRESENTATIVE'S SIGNATURE	DATE

Part 4. To be completed by the location's Safety Officer or safety representative

1. SAFETY OFFICER'S SIGNATURE DATE	2. PRINT NAME HERE	3. TELEPHONE NUMBER ( )
4. SAFETY OFFICER'S COMMENTS (ATTACH ADDITIONAL PAGE(S) IF NECESSARY)		

FOR QUESTIONS: Call the Claims Management Section at 1-866-712-3890, or consult Enterprise Insurance Services SharePoint at: https://stateofwa.sharepoint.com/sites/DSHS-EXE-InsuranceServices.

General Instructions / Distribution

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

Part 1. Should be completed by the employee / volunteer in entirety and in detail within one (1) business day of the incident or their awareness of their injury / illness.

NOTE: If the employee / volunteer is unavailable or unable 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 25) and add the statement, "Completed for unavailable employee / volunteer."

NOTE: If this incident was associated with a client-on-staff assault, and the employee selected "Yes" for both boxes in Block 22, in order to be considered for the Assault benefit, the employee must fill out DSHS form 03-391. Note: Assault benefits may only be adjudicated for DSHS employees who are filling positions authorized by RCW 72.01.045 or RCW 74.04.790.

Part 2. Supervisor completes all requested information, signs and dates document.

Part 3. Use this section only if an employee representative participated in this incident review. The employee representative reviews the requested information and signs.

Part 4. Location's Safety Officer or safety representative completes the requested information and signs.

Distribution:

- DSHS institution / facility supervisors should forward the original DSHS 03-133 (and all added attachments) to the ERMO Insurance Services Office.
- DSHS Headquarters and Field Office supervisors should forward the original DSHS 03-133 (and all added attachments) to the ERMO Insurance Services Office with copies to their local safety committee representative.

Send all documents to:

ERMO Insurance Services Office
PO Box 45882
Mail Stop: 45882
Olympia WA 98504-5882