

# Safety Incident / Close Call Report

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

DATE OF INCIDENT
TIME OF INCIDENT <input type="checkbox"/> AM <input type="checkbox"/> PM

Part 1. To be completed by employee / volunteer			
1. NAME (FIRST, MIDDLE INITIAL, LAST)	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 CURRENT POSITION? <input type="checkbox"/> 0 – 3 mos. <input type="checkbox"/> 4 – 6 mos. <input type="checkbox"/> 7 – 11 mos. <input type="checkbox"/> 1 – 3 yrs. <input type="checkbox"/> 4+ yrs.		
9. SHIFT WORKED <input type="checkbox"/> Day <input type="checkbox"/> Swing <input type="checkbox"/> Night	10. CHECK WHICH DAYS OF THE WEEK EMPLOYEE / VOLUNTEER WORKS <input type="checkbox"/> Mon <input type="checkbox"/> Tues <input type="checkbox"/> Wed <input type="checkbox"/> Thurs <input type="checkbox"/> Fri <input type="checkbox"/> Sat <input type="checkbox"/> Sun <input type="checkbox"/> on call		
11. EMPLOYMENT STATUS OF THE EMPLOYEE / VOLUNTEER <input type="checkbox"/> Permanent / Full-time <input type="checkbox"/> Permanent / Part-time <input type="checkbox"/> Non-permanent <input type="checkbox"/> On-call <input type="checkbox"/> Volunteer <input type="checkbox"/> Non-DSHS Employee <input type="checkbox"/> Contractor <input type="checkbox"/> 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			
<input type="checkbox"/> Abrasion / scratch	<input type="checkbox"/> Bite (human open)	<input type="checkbox"/> Cut	<input type="checkbox"/> Shock / electrocution
<input type="checkbox"/> Ache	<input type="checkbox"/> Bruise	<input type="checkbox"/> Dizziness	<input type="checkbox"/> Sprain / strain
<input type="checkbox"/> Allergic reaction	<input type="checkbox"/> Burn	<input type="checkbox"/> Numbness	<input type="checkbox"/> Swelling / redness
<input type="checkbox"/> Bite (animal / insect)	<input type="checkbox"/> Crush / pinch	<input type="checkbox"/> Puncture	<input type="checkbox"/> Unconsciousness
<input type="checkbox"/> Bite (human closed)	<input type="checkbox"/> Other (specify):		
Further clarification (e.g., degree of burn, origin of bite):			

16. REPORTED BODY PART(S) AFFECTED						
<input type="checkbox"/> Abdomen	<input type="checkbox"/> Back (upper)	<input type="checkbox"/> Ear	<input type="checkbox"/> Glasses	<input type="checkbox"/> Jaw	<input type="checkbox"/> Neck	<input type="checkbox"/> Teeth
<input type="checkbox"/> Ankle	<input type="checkbox"/> Back (lower)	<input type="checkbox"/> Eye	<input type="checkbox"/> Groin	<input type="checkbox"/> Knee	<input type="checkbox"/> Nose	<input type="checkbox"/> Thumb
<input type="checkbox"/> Arm (upper)	<input type="checkbox"/> Buttocks	<input type="checkbox"/> Face	<input type="checkbox"/> Hand	<input type="checkbox"/> Leg (upper)	<input type="checkbox"/> Ribs	<input type="checkbox"/> Toe
<input type="checkbox"/> Arm (lower)	<input type="checkbox"/> Chest	<input type="checkbox"/> Finger	<input type="checkbox"/> Head	<input type="checkbox"/> Leg (lower)	<input type="checkbox"/> Scalp	<input type="checkbox"/> Wrist
<input type="checkbox"/> Artificial appliance	<input type="checkbox"/> Elbow	<input type="checkbox"/> Foot	<input type="checkbox"/> Hip	<input type="checkbox"/> Lungs	<input type="checkbox"/> Shoulder	
<input type="checkbox"/> Other (specify):						
Further clarification (e.g., left leg, right index finger):						

17. WHAT CAUSED THE REPORTED CONDITION			
<input type="checkbox"/> Bitten	<input type="checkbox"/> Contact to hot / cold object	<input type="checkbox"/> Lifting object	<input type="checkbox"/> Pushing / pulling
<input type="checkbox"/> Carrying object	<input type="checkbox"/> Fall due to slip / trip	<input type="checkbox"/> Motor vehicle accident	<input type="checkbox"/> Repetitive motion
<input type="checkbox"/> Caught in / between / under	<input type="checkbox"/> Fall from a height	<input type="checkbox"/> Needle stick	<input type="checkbox"/> Slip / trip no fall
<input type="checkbox"/> Choke / strangle	<input type="checkbox"/> Lifting client	<input type="checkbox"/> Participation in training	
<input type="checkbox"/> Struck. Describe what struck by:			
<input type="checkbox"/> Grabbed. Describe what grabbed by:			
<input type="checkbox"/> Cut. Describe what cut by:			
<input type="checkbox"/> Other (specify):			
Further Clarification (e.g., car passenger, fall on ice):			
Exposure to:	<input type="checkbox"/> Sun / heat	<input type="checkbox"/> Chemicals	<input type="checkbox"/> Loud Noise <input type="checkbox"/> Contaminants
Exposure to:	<input type="checkbox"/> Bodily fluids	<input type="checkbox"/> Diseases	<input type="checkbox"/> 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? .....	<input type="checkbox"/>	<input type="checkbox"/>
3. Was the employee / volunteer made aware of the safety and occupational health hazards associated with their duties / responsibilities?.....	<input type="checkbox"/>	<input type="checkbox"/>
4. Was the employee / volunteer engaged in their regular duties when the incident occurred?.....	<input type="checkbox"/>	<input type="checkbox"/>

	YES   NO
5. Was the employee / volunteer working overtime when the incident occurred? .....	<input type="checkbox"/> <input type="checkbox"/>
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?	<input type="checkbox"/> <input type="checkbox"/>
<b>Note:</b> 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?	<input type="checkbox"/> <input type="checkbox"/>
a. If yes, were the appropriate policies or standards being followed?.....	<input type="checkbox"/> <input type="checkbox"/>
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?	<input type="checkbox"/> <input type="checkbox"/>
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.)? .....	<input type="checkbox"/> <input type="checkbox"/>
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? .....	<input type="checkbox"/> <input type="checkbox"/>
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? .....	<input type="checkbox"/> <input type="checkbox"/>

13. SUPERVISOR'S NAME (PLEASE PRINT)	14. WORK PHONE NUMBER (   )
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15. SUPERVISOR'S SIGNATURE	DATE
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**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 (   )
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3. REPRESENTATIVE'S SIGNATURE	DATE
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**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 (   )
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4. SAFETY OFFICER'S COMMENTS (ATTACH ADDITIONAL PAGE(S) IF NECESSARY)
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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>**

**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 their Safety Officer for further submission to the Enterprise Risk Management Office (ERMO).
- DSHS Headquarters and Field Office supervisors should forward the original DSHS 03-133 (and all added attachments) to the Enterprise Risk Management Office with copies to their local safety committee representative.

**Send all documents to:**

Enterprise Risk Management Office (ERMO)  
PO Box 45882  
Mail Stop: 45882  
Olympia WA 98504-5882

In all cases, offices should retain copies of all submitted documents locally in a readily accessible file, for possible on-site review by ERMO Consultants, Labor and Industries compliance inspectors and other official auditors.

Be sure to distribute additional copies of the completed DSHS 03-133 to:

- Local Safety Committee or Safety Representative (for local review and trend analysis)
- Supervisor
- Employee