

WA DNR

## SUPERVISOR'S REPORT OF INJURY/ILLNESS (OSHA 301)

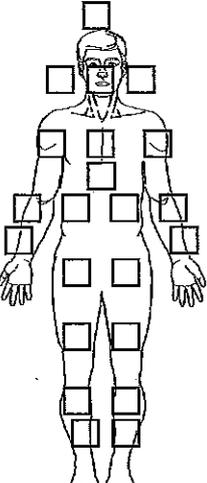
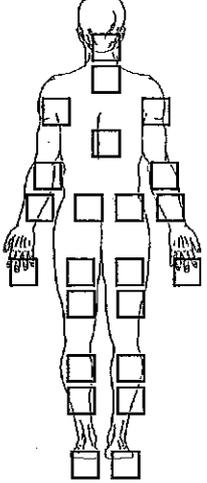
"Double-click" boxes, then select "Checked" or "Not checked" to indicate your choice		<b>OSHA/IIR Case #</b>	
<i>"Injury/Illness" boxes to be marked by HR/Safety/Claims only</i>		Injury/Illness is: <input type="checkbox"/> Recordable <input type="checkbox"/> Non-Recordable	
Injury/illness involves:	<input type="checkbox"/> Lost Time	<input type="checkbox"/> Restricted Duty	<input type="checkbox"/> Job Transfer <input type="checkbox"/> Medical Only
Region/Division:	<input type="checkbox"/> Inmate	<input type="checkbox"/> DNR Employee	<input type="checkbox"/> This form is <u>not</u> complete

### Section 1: Worker Information

First	Middle	Last	<input type="checkbox"/> Male	Supervisor:
			<input type="checkbox"/> Female	
Street ( <u>not</u> PO Box)			City, State, Zip	
Home/Message Phone (     )		-	Birth Date:	Hire Date:

### Section 2: Work Assignment Information

Did injury/illness occur on the employer's premises?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
Exact Location:			
Worker's usual job title?		How long in this job?	
Worker's job title at injury?		How long in this job?	
<b>Date/time injury was first reported:</b>		To whom?	
Time work started:	<input type="checkbox"/> AM <input type="checkbox"/> PM	Name(s) of witnesses:	
What task was the injured worker doing at the time of injury/illness?			
What step was the injured worker doing when the injury occurred?			

 <p><b>Front</b></p>	 <p><b>Back</b></p>	 <p><b>Back</b></p>  <p><b>Front</b></p>	<p><b>What was the injury/illness (mark all that apply)</b></p> <table style="width: 100%;"> <tr> <td><input type="checkbox"/> Strain, sudden</td> <td><input type="checkbox"/> Loss of Consciousness</td> </tr> <tr> <td><input type="checkbox"/> Strain, gradual</td> <td><input type="checkbox"/> Throat/Lung Irritation</td> </tr> <tr> <td><input type="checkbox"/> Sprain</td> <td><input type="checkbox"/> Burn: Heat/Chemical/Radiation</td> </tr> <tr> <td><input type="checkbox"/> Fracture</td> <td><input type="checkbox"/> Puncture/Sliver</td> </tr> <tr> <td><input type="checkbox"/> Cut/Laceration</td> <td><input type="checkbox"/> Hernia</td> </tr> <tr> <td><input type="checkbox"/> Scrape/Abrasion</td> <td><input type="checkbox"/> Chemical Exposure</td> </tr> <tr> <td><input type="checkbox"/> Bruise/Contusion</td> <td><input type="checkbox"/> Hearing Loss</td> </tr> <tr> <td><input type="checkbox"/> Pinch/Crush</td> <td><input type="checkbox"/> Multiple Injuries</td> </tr> <tr> <td><input type="checkbox"/> Eye Irritation (Foreign Body)</td> <td><input type="checkbox"/> Skin Irritation</td> </tr> <tr> <td></td> <td><input type="checkbox"/> Amputation</td> </tr> </table> <p><input type="checkbox"/> Other (describe)</p> <p><b>Did a medical exam result in any of the following:</b></p> <table style="width: 100%;"> <tr> <td><input type="checkbox"/> Fracture (includes chipped tooth)</td> <td><input type="checkbox"/> Stitches, including derma bond</td> </tr> <tr> <td><input type="checkbox"/> Prescription drugs</td> <td><input type="checkbox"/> Third degree burns</td> </tr> <tr> <td><input type="checkbox"/> Restricted work or light duty</td> <td><input type="checkbox"/> Surgery</td> </tr> <tr> <td><input type="checkbox"/> Physical Therapy</td> <td><input type="checkbox"/> Use of devices with rigid stays to immobilize parts of body</td> </tr> <tr> <td><input type="checkbox"/> Unconsciousness</td> <td><input type="checkbox"/> Transfer to another job</td> </tr> <tr> <td><input type="checkbox"/> Amputation (loss of finger tip is considered amputation)</td> <td><input type="checkbox"/> Chiropractic adjustments</td> </tr> </table> <p><input type="checkbox"/> <b>FIRST AID ONLY</b></p>	<input type="checkbox"/> Strain, sudden	<input type="checkbox"/> Loss of Consciousness	<input type="checkbox"/> Strain, gradual	<input type="checkbox"/> Throat/Lung Irritation	<input type="checkbox"/> Sprain	<input type="checkbox"/> Burn: Heat/Chemical/Radiation	<input type="checkbox"/> Fracture	<input type="checkbox"/> Puncture/Sliver	<input type="checkbox"/> Cut/Laceration	<input type="checkbox"/> Hernia	<input type="checkbox"/> Scrape/Abrasion	<input type="checkbox"/> Chemical Exposure	<input type="checkbox"/> Bruise/Contusion	<input type="checkbox"/> Hearing Loss	<input type="checkbox"/> Pinch/Crush	<input type="checkbox"/> Multiple Injuries	<input type="checkbox"/> Eye Irritation (Foreign Body)	<input type="checkbox"/> Skin Irritation		<input type="checkbox"/> Amputation	<input type="checkbox"/> Fracture (includes chipped tooth)	<input type="checkbox"/> Stitches, including derma bond	<input type="checkbox"/> Prescription drugs	<input type="checkbox"/> Third degree burns	<input type="checkbox"/> Restricted work or light duty	<input type="checkbox"/> Surgery	<input type="checkbox"/> Physical Therapy	<input type="checkbox"/> Use of devices with rigid stays to immobilize parts of body	<input type="checkbox"/> Unconsciousness	<input type="checkbox"/> Transfer to another job	<input type="checkbox"/> Amputation (loss of finger tip is considered amputation)	<input type="checkbox"/> Chiropractic adjustments
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<p>Mark the areas of the body that were effected Right <input type="checkbox"/> Left <input type="checkbox"/></p>																																			

### Section 3: Injury/Illness Information

Worker has/is going to get a medical evaluation  Yes  No

First visit date: \_\_\_\_\_ Emergency Room  Yes  No Hospitalized as an In-Patient?  Yes  No

Physician Name: \_\_\_\_\_ Clinic Name & Address: \_\_\_\_\_

Was this a **SUDDEN** injury that can be attributed to a specific event?  Yes  No Date & Time of event: \_\_\_\_\_

**OR** did symptoms develop over time?  Yes  No Date first noticed symptoms: \_\_\_\_\_

Did worker have pre-existing condition or previous injury involving the same body part?  Yes  No  Unknown

If the employee died, what was the date of death? \_\_\_\_\_

**DESCRIPTION OF EVENT:** Describe the activity as well as the tools, equipment, or material the employee was using. Tell us how the injury occurred, and what object or substance directly harmed the employee. Be specific. *Example:* Employee was carrying tools while climbing ladder when the ladder slipped, employee fell 20 feet to concrete floor.

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

#### Contributing Factors

Environmental					Design		
Noise	Wet	Slippery	Animals	Inadequate work space	Restricted access		
Vapor	Dust	Fumes	Temperature	Poor equipment design	Inappropriate tool		
Light	Dark	Ice	Windy	Workplace layout	Congested Area		
Snow	Fog	Smoke		Location; explain			
Systems & Procedures				Human Behavior			
Inadequate Supervision		Housekeeping		Emotion	Distraction	Time crunch	
Incorrect Procedure		No procedure		Fatigue	Unaware	Avoidance	
Inadequate maintenance		Training		Medication	Job skills		

Reference the items marked above to describe the contributing factors below:

#### Determine Causes

**Apparent Causes** (List below)  
 Employee Actions:  
 Environmental Conditions:  
 Equipment Condition:  
 Procedures:  
 Training:  
**Root Causes** (For any "Apparent Causes" above, list Root (Basic) Causes Below)

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Who will implement recommendations, and when?

Name	Action(s)	Est. Date Comp