

**EASTERN OREGON UNIVERSITY**

Office of Human Resources  
One University Blvd.  
La Grande, OR 97850

**SUPERVISOR'S ON-THE-JOB ACCIDENT, ILLNESS INVESTIGATION**

REPORTING ACCIDENT, ILLNESS:

Employee Name: \_\_\_\_\_ Soc. Sec#: \_\_\_\_\_ Dept: \_\_\_\_\_

Date of Accident, Illness: \_\_\_\_\_ Time: \_\_\_\_\_ Work Area: \_\_\_\_\_

Employee's working hours: from \_\_\_\_\_ to \_\_\_\_\_ Employee's scheduled days off: \_\_\_\_\_

Did employee miss work?  NO  YES If YES list date and time employee left work and the date and time employee returned to work:

\_\_\_\_\_

Incident location: \_\_\_\_\_

Did the incident occur on the employer's premises or work site?  YES  NO  UNKNOWN If NO or UNKNOWN explain:

\_\_\_\_\_

\_\_\_\_\_

What was the employee doing at the time of the incident? \_\_\_\_\_

How did the incident occur? Describe body motion such as walking, running, sitting, caught off balance. Did the employee slip, trip or fall?

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Was equipment involved?  NO  YES If YES, describe it or sketch it. Explain its use, how it operates, push levers, foot controls, etc.), and how it was related to the incident. If necessary attach additional pages.

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Was the incident reported by the employee to the supervisor within 24 hours?  YES  NO If NO list reasons and date and time it was reported.

\_\_\_\_\_

\_\_\_\_\_

**MEDICAL TREATMENT**

What parts of the body were involved? \_\_\_\_\_

Did worker seek medical attention? [ ] NO [ ] YES If yes, please have worker complete SAIF FORM 801.

If there was a delay in going to the Doctor, list reason: \_\_\_\_\_

**WITNESSES**

List names, home phone numbers and statements of witnesses. Check for conflicting stories: \_\_\_\_\_

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

List names and home phone numbers of persons employee told about the incident:

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

**AGGRAVATION HANDICAPPED RESERVE THIRD PARTY**

Did the employee have previous injuries or conditions (possibly not work related such as congenital, result of illness, etc.) at or near this particular part of the body: [ ] NO [ ] YES If yes, when, where and how did the injury or condition occur?

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

When did the employee last see a Doctor about this problem? \_\_\_\_\_

List name, address and phone number of the Doctor: \_\_\_\_\_

What was the employee's physical and or emotional condition before the NEW incident occurred? \_\_\_\_\_

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

If the pain "suddenly" or "gradually" occurred, how does the employee relate this problem to work? \_\_\_\_\_

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

Was the incident attributable partially or wholly to a co-worker's pre-existing impairment? [ ] NO [ ] YES If YES explain:

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

Was the incident caused by a person not employed by Eastern?  NO  YES If YES explain and list person's name, address and home phone number:

---

---

**SAFETY/PREVENTION**

Have other employees had incidents at or near this job site?  NO  YES If YES list where, when and how they occurred:

---

---

**SUPERVISOR'S COMMENTS**

Do you know of other activities of the employee that may have contributed to the problem? (pre-existing injury, hobbies, other jobs, personal problems etc).  NO  YES If YES explain:

---

---

---

If your employee is filling a workers compensation claim, do you doubt the validity of the claim?  NO  YES If YES explain:

---

---

---

---

List any other information you have that would help process this claim: \_\_\_\_\_

\_\_\_\_\_  
Supervisor's Signature

\_\_\_\_\_  
Department

\_\_\_\_\_  
Date