Incident Analysis Form (IAF)

Employee Details: _____ Title: _____

Department/Division: _____ Supervisor: _____

INCIDENT TYPES *(Check all that apply)*		Complete Form
INCIDENT ONLY	☐ Incident/near miss (*i.e., no injury or damage*)	• IAF
EMPLOYEE MEDICAL	☐ First Aid *(i.e., minor injury, self-treatment, City Clinic, etc.)*	• IAF • Medical form
	☐ ER/Doctor Visit ☐ Work Restrictions ☐ Time Away From Work	• IAF • Medical form • Call Rapid Care Hot Line (855-959-2741)
	☐ Bloodborne Pathogen or Contagious Disease Exposure	• IAF • Medical form • Exposure Form • Call RISK (see below)
	☐ Overnight Hospitalization[1] ☐ Fatality[1]	• IAF • Call Rapid Care Hot Line (855-959-2741) • *CALL RISK!*
AUTO	☐ City Vehicle Damage ☐ Citizen Auto Damage	• IAF • Vehicle form • DMV form
CITY PROPERTY	☐ City Property Damage/Loss	• IAF • Property Form
CITIZEN INJURY LOSS OR LITIGATION[2]	*Contact HR/Risk and/or have the citizen contact HR/Risk*	
ROUTING INSTRUCTIONS	• **Overnight Hospitalization or Fatality** – CALL HR/RISK ASAP (24 hrs) • **Contagious Pathogen?** – Call Risk within 24 hours. • **Employee**: Complete this form and give it to your supervisor • **Supervisor**: 1) complete the corrective measures section 2) Fax/send draft forms to HR/Risk within 24 hours 3) send signed forms to HR/Risk within 5 calendar days	Risk 541-726-3724 Risk Fax 541-726-4614 After hours? Contact PD dispatch for cell numbers Police 541-726-3714

Basic incident information

Address of Incident: _____

Date/time of incident: _____ Date/time Reported: _____

- Have witnesses been interviewed? ☐ Yes ☐ No ☐ N/A Witness: _____
- Were photos taken? ☐ Yes ☐ No ☐ N/A Witness: _____
- Was the incident reported to Police? ☐ Yes ☐ No ☐ N/A PD Case Number: _____
- Citizen injury or property damage? ☐ Yes ☐ No ☐ N/A Name of Suspect: _____

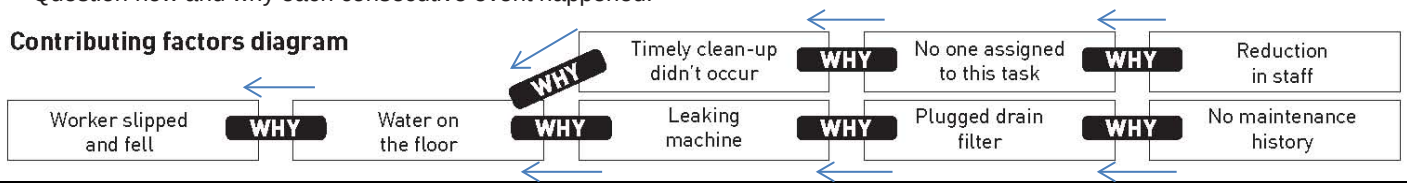
Describe the incident in detail

- What were you doing just before the incident happened?
- **INJURIES**? Who was injured? What body parts were injured? Where were the injured individuals treated?
- **VEHICLE**? What vehicles were involved? List vehicle/unit/license numbers. Driver names. Where are the vehicles now?
- *Use additional sheets and attach photos, documents, etc. as necessary.*

Track sequence & identify root causes

Reconstruct the series of events leading ***back in time*** to the root cause(s) of the event.

- Use the diagram below as a possible example.
- What happened before, during and after the incident?
- Question how and why each consecutive event happened.



Recommendation(s)

Employee & Supervisor – Please note any recommendations that may help prevent injury in the future

- Identify multiple solutions to eliminate or reduce multiple root causes.
- Identify improvements to safety processes and/or procedures.

Follow Up Recommendation(s) (*Please mark NA if none)* ☐

Completed By (If not Employee): _____ Signature: _____ Date: _____

Employee: _____ Signature: _____ Date: _____

Supervisor: _____ Signature: _____ Date: _____

Safety Committee: _____ Signature: _____ Date: _____

(See front for routing instructions)

HR/Risk Use:

Date HR/Risk Notified: _____ PD Case #: _____ Suspects Name: _____

Claim Numbers:_____

Supplemental Medical Form

Injured Employee: _____ Title: _____

Dept./Division: _____ Supervisor: _____

Incident Date/Time: _____ Location: _____

Was an Incident Analysis Form (IAF) Completed? ☐ Yes ☐ No, but will soon.

Has an 801 been completed? ☐ Yes ☐ No, but will soon, ☐ N/A

Treatment

CALL RISK ASAP! → ☐ Fatality ☐ Overnight Hospitalization

Call RISK 24 hrs → ☐ Biological Exposure or needle stick

Complete 801 → ☐ ER ☐ Urgent Care ☐ Dr. Visit ☐ Lost Time ☐ Modified Duty

IAF Only → ☐ MedExpress ☐ Report Only – no injury

Body Part Affected (Check all that apply)

☐ Left ☐ Right

☐ Head	☐ Face	☐ Eye	☐ Mouth	☐ Neck	☐ Shoulder
☐ Arm	☐ Wrist/Hand	☐ Finger	☐ Chest	☐ Abdomen	☐ Hip/Groin
☐ Upper Back	☐ Lower Back	☐ Leg	☐ Knee	☐ Ankle	☐ Foot/Toe

Injury Type

☐ Sprain/Strain	☐ Contusion	☐ Laceration	☐ Fracture
☐ Burn	☐ Eye Injury	☐ Hearing	☐ Concussion
☐ Needle stick	☐ Biological Exposure	☐ Occupational Disease	

Task(s) that led to injury (Check all that apply)

☐ Lifting	☐ Carrying	☐ Push/Pull	☐ Reaching	☐ Bending	☐ Twisting
☐ Climbing	☐ Walking	☐ Running	☐ Operating	☐ Driving	☐ Handling

Other involved Factors (Check all that apply)

☐ Housekeeping	☐ Repetitive Use	☐ Equipment Failure
☐ Chemical Use	☐ Environment	☐ Material Handling
☐ Weather	☐ Lack of PPE/Safety Equip.	☐ Lock Out/Tag Out
☐ Fatigue	☐ Animal	☐ Tool Use
☐ Other Person/Liable Party	☐ Self-rescue	☐ Rescue

Include any additional relevant information not included on the IAF form.

Completed By: _____ Signature: _____ Date: _____

Supervisor: _____ Signature: _____ Date: _____

HR/Risk Use:

Date HR/Risk Notified: _____ IAF Incident Number: _____

saif

400 High St. SE
Salem, OR 97312

For SAIF Customer Use
Area ____ ____ ____
Dept. ____
Shift ____ CC ____

CLAIM NO. ____
SUBJECT DATE ____
CLASS ____
DEFAULT DATE ____
EMPLOYER'S ACCOUNT NO. 100035575

Email: saif801@saif.com
Toll-free phone: 1.800.285.8525
Toll-free FAX: 1.800.475.7785

Report of Job Injury or Illness*

Workers' compensation claim

To make a claim for a work-related injury or illness, fill out this form and give to your employer.

If you do not intend to file a workers' compensation claim with SAIF, do not sign the signature line. Your employer will give you a copy.

1. Date of injury or illness: / /	2. Date you left work: / /	3. Time you began work on day of injury: ☐ a.m. ☐ p.m.	4. Regularly scheduled days off: ☐ M ☐ T ☐ W ☐ T ☐ F ☐ S ☐ S	**DEPT USE:**
5. Time of injury or illness: ☐ a.m. ☐ p.m.	6. Time you left work: ☐ a.m. ☐ p.m.	7. Shift on day of injury: (from) ☐ a.m. ☐ p.m. (to) ☐ a.m. ☐ p.m.		Emp
8. What is your illness or injury? What part of the body? Which side? (Example: sprained right foot) ☐ Left ☐ Right			9. Check here if you have more than one job: ☐	Ins
10. What caused it? What were you doing? Include vehicle, machinery, or tool used. (Example: Fell 10 feet when climbing an extension ladder carrying a 40-pound box of roofing materials)				Occ
				Nat
				Part
				Ev
				Src
				2src

Information ABOVE this line: date of death, if death occurred; and Oregon OSHA case log number must be released to an authorized worker representative upon request.

11. Your legal name:	12. Language preference:	13. Birthdate: / /	14. Gender: ☐ M ☐ F
15. Your mailing address: City: State: ZIP:			16. Mobile/home phone:
17. Occupation:			18. Work phone:
19. Names of witnesses:		20. Your email address (Optional):	
21. Name and phone number of health insurance company: PacificSource Health 855-896-5208		22. Name and address of health care provider who treated you for the injury or illness you are now reporting:	
23. Have you previously injured this body part? ☐ Yes ☐ No			
24. Were you hospitalized overnight as an inpatient? ☐ Yes ☐ No			
25. Were you treated in the emergency room? ☐ Yes ☐ No			

26. By my signature, I am making a claim for worker's compensation benefits. The above information is true to the best of my knowledge and belief. I authorize health care providers and other custodians of claim records to release relevant medical records to the workers' compensation insurer, self-insured employer, claim administrator, and the Oregon Department of Consumer and Business Services. **Notice:** Relevant medical records include records of prior treatment for the same conditions or of injuries to the same area of the body. A HIPAA authorization is not required (45 CFR 164.512(I)). Release of HIV/AIDS records, certain drug and alcohol treatment records, and other records protected by state and federal law requires separate authorization. **I understand I have a right to see a health care provider of my choice subject to certain restrictions under ORS 656.260 and ORS 656.325.**

27. Worker signature:	28. Completed by (please print):	29. Date: / /

Employer at time of injury

Complete the rest of this form and give a copy of the form to the worker. If the worker is unavailable, complete with available information. Notify SAIF within five days of knowledge of the claim. Even if the worker does not wish to file a claim, maintain a copy of this form.

30. Employer legal business name: City of Springfield	31. Phone: 541-726-3788	32. FEIN: 93-6002258
33. If worker leasing company, list client business name:		34. Client FEIN:
35. Address of principal place of business (not P.O. Box): 225 5th Street, Springfield, OR 97477		36. Insurance policy no.: 100035575
37. Street address from which worker is/was supervised: ZIP:		38. Nature of business in which worker is/was supervised: Municipality
39. Address where event occurred:		
40. Was injury caused by failure of a machine or product, or by a person other than the injured worker? ☐ Yes ☐ No		41. Class code:
42. Were other workers injured? ☐ Yes ☐ No	43. Did injury occur during course and scope of job? ☐ Unknown ☐ Yes ☐ No	44. OSHA 300 log case no:

45. Date employer knew of claim:	46. Worker's weekly wage: $	47. Date worker hired:	48. If fatal, date of death

49. Return-to-work status: Not returned ☐ ☐ Regular Date: / / ☐ Modified Date: / / If modified work, is it regular hours and wages? ☒ Yes ☐ No

By my signature, I acknowledge I am responsible for notifying my workers' compensation insurance company within five days of knowledge of the claim. **I understand I may not restrict the worker's choice of or access to a health care provider. If I do, it could result in civil penalties under ORS 656.260.**

50. Employer signature:	51. Name and title (please print): Deanna Judd, Claim Analyst	52. Date: / /

801
Form 801 12.20

OSHA requirements: Employers must report work-related fatalities and catastrophes to Oregon OSHA either in person or by telephone within eight hours. In addition, employers must report any in-patient hospitalization, loss of an eye, and any amputation or avulsion that results in bone or cartilage loss to Oregon OSHA within 24 hours. See OAR 437-001-0704. Call 800.922.2689 (toll-free), 503.378.3272, or Oregon Emergency Response, 800.452.0311 (toll-free), on nights and weekends.

**This form was modified by SAIF Corporation, and has been approved for use by the Oregon Workers' Compensation Division.*

A guide for workers recently hurt on the job

The following information is provided by SAIF at the request of the Workers' Compensation Division

saif
400 HIGH ST. SE, SALEM, OR 97312

How do I file a claim?

- Notify your employer and a health care provider **of your choice** about your job-related injury or illness as soon as possible. Your employer cannot choose your health care provider for you
- Ask your employer the name of its workers' compensation insurer.
- Complete **Form 801, "Report of Job Injury or Illness,"** available from your employer and **Form 827, "Workers' and Health Care Provider's Report for Workers' Compensation Claim,"** available from your health care provider.

How do I get medical treatment?

- You may receive medical treatment from the health care provider **of your choice**, including:
  - Authorized nurse practitioners
  - Chiropractic physicians
  - Medical doctors
  - Naturopathic physicians
  - Oral surgeons
  - Osteopathic physicians
  - Physician assistants
  - Podiatric physicians
  - Other health care providers
- The insurance company may enroll you in a managed care organization at any time. If it does, you will receive more information about your medical treatment options.

Are there limitations to my medical treatment?

- **Health care providers may be *limited* in how long they may treat you and whether they may authorize payments for time off work.** Check with your health care provider about any limitations that may apply.
- **If your claim is denied, you may have to pay for your medical treatment.**

If I can't work, will I receive payments for lost wages?

- You may be unable to work due to your job-related injury or illness. In order for you to receive payments for time off work, your health care provider must send written authorization to the insurer.
- Generally, you will not be paid for the first three calendar days for time off work.
- You may be paid for lost wages for the first three calendar days if you are off work for 14 consecutive days or hospitalized overnight.
- If your claim is denied within the first 14 days, you will not be paid for any lost wages.
- Keep your employer informed about what is going on and cooperate with efforts to return you to a modified- or light-duty job.

What if I have questions about my claim?

- SAIF or your employer should be able to answer your questions. Call SAIF at 800.285.8525.
- If you have questions, concerns, or complaints, you may also call any of the numbers below:

Ombudsman for Injured Workers:
(an advocate for injured workers)

Toll-free: 800.927.1271

Email: oiw.questions@oregon.gov

Workers' Compensation Resolution Section

Toll-free: 800.452.0288

Email: workcomp.questions@oregon.gov

Do I have to provide my Social Security number on Forms 801 and 827? What will it be used for?
You do not need to have an SSN to get workers' compensation benefits. If you have an SSN, the Workers' Compensation Division (WCD) of the Department of Consumer and Business Services will get it from your employer, the workers' compensation insurer, or other sources. WCD may use your SSN for the following: quality assessment, correct identification and processing of claims, compliance, research, injured worker program administration, matching data with other state agencies to measure WCD program effectiveness, injury prevention activities, and to provide to federal agencies in the Medicare program for their use as required by federal law. The following laws authorize WCD to get your SSN: the Privacy Act of 1974, 5 USC § 552a, Section (7)(a)(2)(B); Oregon Revised Statutes chapter 656; and Oregon Administrative Rules chapter 436 (Workers' Compensation Board Administrative Order No. 4-1967).

Form 3283* | SAIF 12.20 (440-3283, 01/21/DCBS/WCD/WEB) for distribution with Form 801.
**This form was modified by SAIF Corporation, and has been approved for use by the Oregon Workers' Compensation Division.*

Return form to: **City of Springfield**
Attn: DeeDee Judd
225 5th Street
Springfield, OR 97477
FAX: 541-726-4614 PH: 541-726-3788

RETURN-TO-WORK STATUS

Worker's name: _____ Claim number (if known): _____

Next scheduled appointment date: _____

Is the worker expected to materially improve from medical treatment or the passage of time? ☐ Yes ☐ No

WORK STATUS *(Select one option)*

☐ **OPTION 1 – Released to Regular Work** Status from (date): _____

Released to the ***hours routinely worked and tasks routinely performed in the job held at the time of injury.***

☐ **OPTION 2 – Not Released to Work** Status from (date): _____ to: _____

The worker is ***not capable of performing any work activities***.

☐ **OPTION 3 – Released to Modified Work** Status from (date): _____ to: _____

Released to work, ***subject to the following work restrictions (note only those that are applicable):***

Total work hours: ____ hours/day

Lift/carry/push/pull restrictions

	One-time	*≤1/3 of workday*	*1/3-2/3 of workday*	*≥2/3 of workday*	*Duration*	
Lift:	____ pounds	____ pounds	____ pounds	____ pounds	____ hrs./day	____ hrs./one time
Carry:	____ pounds	____ pounds	____ pounds	____ pounds	____ hrs./day	____ hrs./one time
Push:	____ pounds	____ pounds	____ pounds	____ pounds	____ hrs./day	____ hrs./one time
Pull:	____ pounds	____ pounds	____ pounds	____ pounds	____ hrs./day	____ hrs./one time

Activity restrictions

Stand:	____ hrs./day	____ hrs./one time	***Twist:***	____ hrs./day	____ hrs./one time	***Crawl:***	____ hrs./day	____ hrs./one time
Walk:	____ hrs./day	____ hrs./one time	***Climb:***	____ hrs./day	____ hrs./one time	***Crouch:***	____ hrs./day	____ hrs./one time
Sit:	____ hrs./day	____ hrs./one time	***Bend:***	____ hrs./day	____ hrs./one time	***Balance:***	____ hrs./day	____ hrs./one time
Drive:	____ hrs./day	____ hrs./one time	***Above-shoulder-reach:***	____ hrs./day	____ hrs./one time	***Below-shoulder-reach:***	____ hrs./day	____ hrs./one time
Kneel:	____ hrs./day	____ hrs./one time						

Hand use restrictions

Fine actions:	____ hrs./day L hand	____ hrs./day R hand
Keyboarding:	____ hrs./day L hand	____ hrs./day R hand
Grasp:	____ hrs./day L hand	____ hrs./day R hand

Foot use restrictions

Raise:	____ hrs./day L foot	____ hrs./day R foot
Push:	____ hrs./day L foot	____ hrs./day R foot

Notes / other restrictions: _____

_____

Medical provider's signature: _____ Date: _____

Print medical provider's name: _____ Phone no.: _____

Incident Number: _____

Police Department
Bloodborne Pathogen Exposure Form

Incident Date/Time: _____ Location:_____SPD Case # _____

Involved Officer: _____

Was an Incident Analysis Form (IAF) Completed?	☐ Yes	☐ No, but will soon.
Was a Supplemental Medical Form Completed?	☐ Yes	☐ N/A (no employee injuries)
Was an 801 form completed?	☐ Yes	☐ N/A

Source Information

Name: _____

DOB: _____

Address: _____

1. List protective equipment, if any, you were wearing at the time of the incident:
   ☐ Latex gloves ☐ Leather gloves ☐ Glasses ☐ Goggles ☐ Mask ☐ Face shield
   ☐ Long sleeve shirt ☐ Short sleeve shirt ☐ Other _____
2. List the sites from which the source was bleeding?
3. Exactly where was your body, face, equipment or clothing contaminated with the source's blood?
4. How much of the source's blood was present?
   Examples might be: small flecks or spots of blood on the back of my right hand and blood smeared on most of my right forearm; my right and left arms were covered with source's blood. ***We are required to report the amount of blood present. If you were contaminated with a large quantity of blood, then we are required to refer for medical evaluation****.*
5. How long was the blood present before you were able to wash? What did you cleanse with?
6. Was <u>your</u> skin intact at the time of the incident? ☐ Yes ☐ No
   a. Please describe the type and location of your wounds (*Examples: hands were chafed, scratched, cut or scraped)*
   b. Did you have hangnails? ☐ Yes ☐ No
   c. How old were your wounds? _____
   d. Were any of your wounds contaminated?_____
   e. If so, which ones? _____

7. Did your eye(s) get contaminated with saliva or blood? ☐ Yes ☐ No
   a. Were you wearing glasses? ☐ Yes ☐ No
   b. Were you able to wash out your eyes? ☐ Yes ☐ No
   c. Was blood present in the source's saliva or were his/her gums or mouth bleeding or in poor condition? ☐ Yes ☐ No
   d. How did the eye contamination occur?

8. Did your mouth get contaminated with saliva or blood? ☐ Yes ☐ No
   e. Did you have cuts or open wounds in your mouth? ☐ Yes ☐ No
   f. Was blood present in the source's saliva or were his/her gums or mouth bleeding or in poor condition? ☐ Yes ☐ No

9. Where is the source now? ☐ LCJ ☐ springfield Municipal Jail ☐ CLC'd ☐ Unknown

10. Are you requesting follow-up testing and a medical evaluation due to this exposure? ☐ Yes ☐ No

If yes, a blood draw needs to be done from the source person and notification must be made to Cascade Health Solutions to schedule an apt for employee blood draw and follow-up testing. Phone 541-228-3100

For source testing, contact MedExpress at 541-228-3111 – this is a 24 hour dispatch line. If suspect is not cooperative a court order will need to be obtained. (LCJ Medical staff will NOT provide any assistance in obtaining the blood draw.) If custody is cooperative, hospital staff may be able to assist in source blood draw, assuming suspect hasn't already been lodged at LCJ – in that case, MedExpress needs to handle the blood draw.

Was MedExpress contacted and arrangements made for source testing? ☐ Yes ☐ No

If no, please explain the reason no follow-up testing is requested. Examples: skin intact, no actual exposure to open skin; exposure minimal.

11. Do you have any additional information which may be important for your record and this exposure?

Officer's Name:_____ Signature: _____ Date: _____

Supervisor Name: _____ Signature: _____ Date: _____

HR/Risk Use:
Date HR/Risk Notified: _____ Incident Number: _____