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: ___________________________________

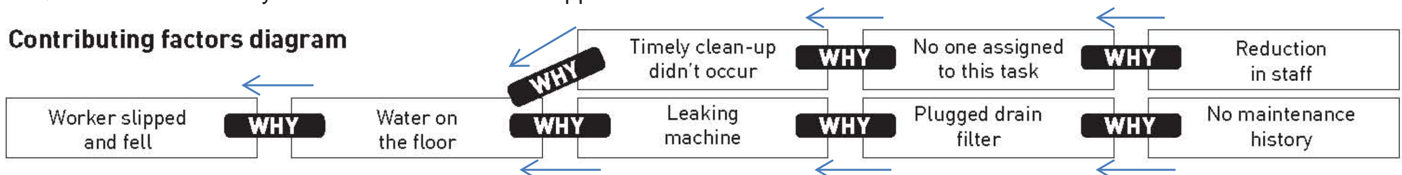
Describe the incident in detail

- 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: ________

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:	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.	☐ M ☐ T ☐ W ☐ T ☐ F ☐ S ☐ S	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.: __________