CITY OF PULLMAN
SUPERVISOR & EMPLOYEE REPORT OF EMPLOYEE INJURY/ACCIDENT

NOTE: The information contained in this form is used to complete the most recent OSHA 300 Log, a federally mandated listing of work-related injury/accidents and/or illnesses. This form is to be signed by the employee, and it is to be reviewed by the employee's supervisor. The supervisor shall submit the completed form to the Safety Officer (Human Resources Manager) or Deputy City Clerk within 24 hours of the work-related injury/accident or onset of work-related illness.

Date of Report: _____/______/_____ **Spillman CAD #_______________**
Employee Name ____
EmployeeAddress____
Telephone Number (___)_____-___________ Social Security Number ____-___-_______
Date of Birth _____/_____/______ Age ____________ ☐ Male ☐ Female
JobTitle ____Date of Hire _____/_____/_____
Date of Injury ____/____/____ Time of Injury ______ am ______ pm
Shift Hours: Start _____ am _____ pm End ______ am ______ pm

Witness(es) to the Accident/Injury, if applicable

Name_________________________________ Name _________________________________
Address_______________________________ Address________________________________
Telephone (_____)______-_______________ Telephone (_____)______-________________

ACCIDENT/INJURY INFORMATION

1. Where did the accident/injury occur? (Be specific. *Example: "parking lot between city hall and police department.")*

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2. What were you doing just before the accident occurred? (Describe the activity as well as the tools, equipment, or materials you were using. Be specific. *Example: "Climbing a ladder while carrying roofing materials"; " spraying chlorine from hand sprayer"; "daily computer key entry")*

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3. How did the injury occur? (*Examples: "When ladder slipped on wet floor, I fell 10 feet"; "I was sprayed with chlorine when gasket broke on sprayer during replacement"; "I developed soreness in wrist over time").*

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4. What was the injury or illness? What part of the body was affected? How was it affected? Be specific. (*Examples: "strained back"; "chemical burn, right hand"; "carpal tunnel syndrome").*

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5. What object or substance directly harmed you? (*Example: "Concrete floor"; "chlorine"; "radial arm saw").*

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6. Did an unsafe condition exist, and/or was an unsafe act committed? Explain.

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7. What can be done to prevent this type of injury/illness from reoccurring?

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8. Have you ever had prior conditions or similar injuries? _____ Yes _____ No
(If YES, please describe. Include date, if employed when injured and by whom, how injury occurred, and what body part(s) was/were affected on prior injury.)

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Medical Treatment

1. Was first aid rendered at the job site? ____ Yes ___ No: Medical Facility?____Yes____No

   a. Name of Medical Facility.____
   b. Address:______________________City____________State___ Zip_____
   c. Name of physician or other health care professional. ____________________________
   d. Were you treated in an emergency room? ___Yes___No
   e. Were you hospitalized as an in patient? Yes ___No

2. Did injury require: ____ sutures ____ splint ____ cast _____ shots (tetanus) ____ Other (specify)

____

3. Did injury result in days away from work? ___ Yes ___No ___Don't Know
   Days of restricted activity? ___Yes ___ No ___ Don't Know

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DIRECTIONS: Circle one or more code number(s) for each category, as appropriate.

EMPLOYEE CLASSIFICATION

1. Regular-Full Time
2. Regular-Part Time
3. Trial Employee
4. Casual, Seasonal,or temporary
5. Volunteer

TYPE OF ACCIDENT/INJURY

1. Slip or fall on same level
2. Slip or fall to different level
3. Struck by falling/flying object
4. Contact with tools/knives/power equip.
5. Contact with extreme temperatures
6. Contact with electric current
7. Contact with/by liquid/gas/vapor/solid
8. Ran into: ____________________________
9. Caught in/on/under/between: ____________
10. Exposed to disease/parasite/other
11. Over exertion (lifting/pulling/pushing)
12. Not known

Employee's Signature ____ Date ____/____/____

IMMEDIATE SUPERVISOR COMMENTS

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Supervisor' Signature ____ Date ____/____/____

DEPARTMENT HEAD COMMENTS

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____
____

Department Head Signature____________________________________ Date ____/____/____

SAFETY OFFICER'S REVIEW

Employee sustained minor injury (first aid only) _____ Yes _____ No
Employee sustained moderate injury (treatment in excess of minor first aid) _____ Yes _____ No
Employee died _____ Yes _____ No Date of death _____/_____/______
Time Loss _____ Yes _____ No From _____/_____/_____ To _____/_____/_____
Restricted activity _____ Yes _____ No From _____/_____/_____ To _____/_____/_____

Safety Officer's Signature _____________________________________ Date _____/_____/_____

City Supervisor's Signature _____________________________________ Date _____/_____/_____