

Supervisor's Review of Safety Incident / Near Miss Report

*Please read the General Instructions / Distribution information
on Page 3 prior to completing this form.*

DATE OF INCIDENT	INCIDENT TYPE <input type="checkbox"/> Near Miss <input type="checkbox"/> Injury
TIME OF INCIDENT <input type="checkbox"/> AM <input type="checkbox"/> PM	

Part 1. Affected employee / volunteer identification from the submitted 03-133

1. NAME OF AFFECTED EMPLOYEE (LAST, FIRST, MI)	2. DATE OF BIRTH	3. EMPLOYEE ID NUMBER
4. EMPLOYMENT STATUS OF THE AFFECTED EMPLOYEE <input type="checkbox"/> Permanent / Full-time <input type="checkbox"/> Permanent / Part-time <input type="checkbox"/> Non-permanent <input type="checkbox"/> On-call <input type="checkbox"/> Volunteer <input type="checkbox"/> Other		

Part 2. Review of incident by supervisor / manager. Please complete the form in its entirety. If you have questions, contact your Safety Officer / Safety Representative, or call the Claims Management Section at 1-866-712-3890.

	YES	NO	N/A
1. Has a Job Hazard Assessment (JHA) been completed for the position the affected employee is assigned?	<input type="checkbox"/>	<input type="checkbox"/>	
2. Was the affected employee fully orientated to their current position and made aware of the safety and occupational health hazards associated with their duties / responsibilities?	<input type="checkbox"/>	<input type="checkbox"/>	
3. Are the JHA and the employee's orientation position-related safety and health hazard briefings documented?	<input type="checkbox"/>	<input type="checkbox"/>	
4. Was the affected engaged in their regular duties when the incident occurred?	<input type="checkbox"/>	<input type="checkbox"/>	
5. Did the incident occur in the employee's regular assigned work areas?	<input type="checkbox"/>	<input type="checkbox"/>	
a. If no, where did the incident take place? _____			
b. If no, why was the affected employee at that different location? <input type="checkbox"/> Pulled <input type="checkbox"/> On-call <input type="checkbox"/> Training <input type="checkbox"/> Transiting <input type="checkbox"/> Meal / break <input type="checkbox"/> Other (specify): _____			
c. If no, was the affected employee orientated to the non-regular work location where the incident occurred?	<input type="checkbox"/>	<input type="checkbox"/>	
6. Was the employee working overtime when the incident occurred?	<input type="checkbox"/>	<input type="checkbox"/>	
a. If yes, how many hours straight had the employee been working? _____			
b. How many overtime shifts had the employee worked in the seven (7) days prior to the incident? _____			
7. Was First Aid administered following the incident?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Was hospitalization or medical treatment beyond first aid provided / sought for the employee following the incident? ..	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Are lost work days or is medical treatment beyond first aid expected or reasonably anticipated as a result of this incident?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Note: For incidents resulting in employee death, unconsciousness, days away from work, amputations, loss of one or both eyes, work restrictions, or medical treatment beyond first aid, an Employee Representative should be identified to assist in this review (see Part 4 below).			
10. If the affected employee is out on loss work days, what was the date of their last day of work? _____			
11. Was the affected employee exposed to someone else's blood or other body fluids?	<input type="checkbox"/>	<input type="checkbox"/>	
Note: If yes, please ensure that the affected employee has been advised to consult with a medical provider and that a Post-Exposure Report, DSHS form 03-333, is submitted.			
12. Was Personal Protective Equipment (PPE) required to be used by the employee at the time of the incident?	<input type="checkbox"/>	<input type="checkbox"/>	
a. If yes, was appropriate PPE being used?			
b. If PPE was required and not being used in this circumstance, please explain why not.			
13. Was lifting assistance or lifting equipment required to be used by the employee at the time of the incident?	<input type="checkbox"/>	<input type="checkbox"/>	
a. If yes, was appropriate lifting assistance or lifting equipment being used?			
b. If lifting equipment was required and not being used in this circumstance, please explain why not.			
14. Were there current DSHS, Administration, Division, Region, Facility, or other local policy or standard operating procedures governing the activities being performed by the employee at the time of the incident?	<input type="checkbox"/>	<input type="checkbox"/>	
a. If yes, were the appropriate policies or standards being followed?			
b. If policies / standards were required to be followed, but were not in this circumstance, please explain why not.			
15. Per your review was the incident a direct result of client interaction / contact?	<input type="checkbox"/>	<input type="checkbox"/>	
a. If yes, did the client initiate the physical contact?			
16. Did the incident occur while the employee was restraining or attempting to restrain an out of control client?	<input type="checkbox"/>	<input type="checkbox"/>	

	YES	NO	N/A
17. a. Was the affected employee the recipient of unauthorized touching by a hostile, aggressive or out-of-control client?	<input type="checkbox"/>	<input type="checkbox"/>	
b. If there was unauthorized touching by a client, did it result in a physical injury to the employee?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. If the touching resulted in a physical injury, did the injury require immediate medical attention beyond first aid, or is it reasonably anticipated to require medical attention beyond first aid in the future?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Note: If the reply to all three items in Item 17 above is "YES," ensure that the injured / ill employee completes DSHS form 03-391, and witnesses complete DSHS 03-389A.			
18. Did you conclude the incident to be the result of an unsafe physical WORK ENVIRONMENT ?	<input type="checkbox"/>	<input type="checkbox"/>	
a. If yes, please describe the specific safety / health hazard(s) that contributed:			
b. If yes, please describe the actions you have taken to correct the safety or health hazards.			
19. Did you conclude the incident was the result of an unsafe WORK PRACTICE or PROCEDURE ?	<input type="checkbox"/>	<input type="checkbox"/>	
a. If yes, please describe the unsafe work practice / procedure:			
b. Please describe the actions you have taken to correct the unsafe work practice.			
20. To help prevent future reoccurrences, did you discuss the incident and corrective actions with the affected employee and the remainder of your staff?	<input type="checkbox"/>	<input type="checkbox"/>	
a. If no, please explain why not.			
b. What other actions have you taken to prevent a reoccurrence of similar incidents?			
21. Based on your review, does this incident require further investigation?	<input type="checkbox"/>	<input type="checkbox"/>	

Part 3. Supervisor's identification

1. SUPERVISOR'S NAME (PLEASE PRINT)	2. WORK PHONE NUMBER ()	3. SUPERVISOR'S EMPLOYEE ID NO.
4. SUPERVISOR'S WORK ADDRESS	CITY	STATE ZIP CODE
5. SUPERVISOR'S SIGNATURE	DATE	

Part 4. Employee representative review (shop steward or designated individual) per WAC 296-800-32020

1. EMPLOYEE REPRESENTATIVE'S NAME (PLEASE PRINT)	2. TELEPHONE NUMBER ()	3. REPRESENTATIVE'S EMPLOYEE ID NO.
4. EMPLOYEE REPRESENTATIVE'S WORK ADDRESS	CITY	STATE ZIP CODE
5. REPRESENTATIVE'S SIGNATURE	DATE	

Part 5. To be completed by the location's Safety Officer or safety representative

1. SAFETY OFFICER'S SIGNATURE	DATE	2. PRINT NAME HERE	3. TELEPHONE NUMBER ()
4. SAFETY OFFICER'S COMMENTS (ATTACH ADDITIONAL PAGE(S) IF NECESSARY)			

Part 6. To be completed by the employee's CEO / Superintendent / Administrator if all blocks in Part 2, Item 18 are answered "yes," and following review of DSHS forms 03-133, 03-391, 03-389A, and any other pertinent documents.

1. PAYMENT OF ASSAULT BENEFITS ARE: <input type="checkbox"/> Recommended <input type="checkbox"/> Not recommended	2. CEO / SUPERINTENDENT / ADMINISTRATOR'S REASON FOR NOT RECOMMENDING
3. SIGNATURE	DATE

FOR QUESTIONS: Call the Claims Management Section at 1-866-712-3890, or consult the Claims Section website at: <http://one.dshs.wa.lcl/FS/Loss/WorkersComp/Pages/default.aspx>

GENERAL INSTRUCTIONS

For purposes of this form, a “Near Miss” incident is any event that could have resulted in an on-the-job employee injury or death, but fortunately did not. Reporting of “Near Miss” events enables the Department to use the information to help prevent future incidents and the possibility of future injuries.

Note: Parts 1- 3 should be completed by the affected employee’s immediate supervisor.

Part 1 – Supervisor completes Date of Incident, Time of Incident, Name, Date of Birth, and Employee ID Number with information provided by affected employee in the Safety Incident / Near Miss, DSHS 03-133. Complete remainder of information per employee’s personnel records.

Part 2 - Supervisor completes all requested information.

Part 3 - Supervisor completes all items and signs.

Part 4 – Use this section only if an employee representative participated in this incident review. The employee representative completes the requested information and signs.

Part 5 – Location’s Safety Officer or safety representative completes the requested information and signs.

Part 6 – If this incident was associated with a client-on-staff assault, the location’s CEO/Superintendent/Administrator, or their designated representative, completes the requested information and signs as necessary. **Note: Payment of assault benefits may only be approved for DSHS employees who are filling positions authorized by RCW 72.01.045 or RCW 74.04.790.**

DISTRIBUTION: DSHS institution/facility supervisors should forward the original DSHS 03-133 and DSHS 133A (and all added attachments) to their Safety Officer for further submission to the Enterprise Risk Management Office.

DSHS Headquarters and Field Office supervisors should forward the original DSHS 03-133 and DSHS 133A (and all added attachments) to the Enterprise Risk Management Office with copies to their local safety committee representative.

Send all documents to:

Enterprise Risk Management Office (ERMO)

PO Box 45882

Mail Stop: 45882

Olympia WA 98504-5882

In all cases, offices should retain copies of all submitted documents locally in a readily accessible file, for possible on-site review by ERMO Consultants, Labor and Industries compliance inspectors and other official auditors.

Be sure to distribute additional copies of the completed DSHS 03-133 and DSHS 03-133A to:

Local Safety Committee or Safety Representative (for local review and trend analysis)

Supervisor

Employee