Employee Incident/Accident Report

Reporting Work-Related

- ☐ Death Date:_____
- ☐ Injury
- ☐ Illness
- ☐ Near Miss

(if city vehicle involved, please attach completed Accident Report)

Date of incident:

Department

- ☐ Police Department
- ☐ Fire Department
- ☐ Public Works Department
- ☐ City Clerk's Office
- ☐ Legal
- ☐ Mayor's Office
- ☐ Commissioners' Office
- ☐ Other _____

EMPLOYEE/WAGE

Name (Last, First, M.I.)	Date of Birth	Social Security Number	Date Hired
		/ /	

Mailing Address (Incl. Zip)	Marital Status	Employment Status	Occupation/Job Title
	☐ Unmarried/Single/Dlivorced (U) ☐ Married (M) ☐ Separated (S)	☐ Full Time (F) ☐ Part-Time (P) ☐ Temporary (T)	Rate Per: ◯ Bi-Weekly ◯ Hr.

Physical Address	Gender	#of Dependents	#Days Worked /Week	# Hrs. Worked/Day
	◯ Male ◯ Female			

Phone	Full pay for day of injury?	Yes	No
	Did salary continue?	Yes	No

OCCURRENCE/TREATMENT A drug screen is REQUIRED for accidents and MUST be authorized by Personnel or designated staff.

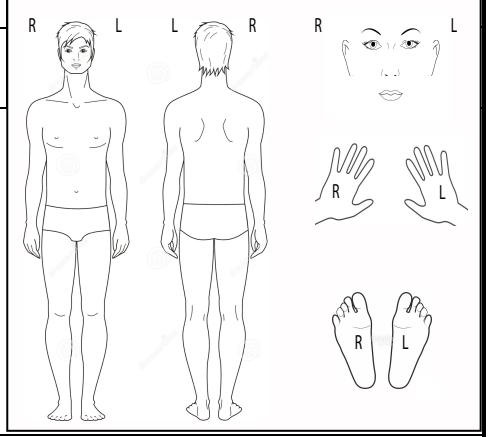
Time Employee Began Work	Date of Injury/Illness	Time of Occurrence	Last Work Date	County Where Incident Occurred	Date Employer Notified
☐ AM ☐ PM		☐ AM ☐ PM			

List All Affected Body Parts (Ex: "strained back: chemical burn –right hand, carpal tunnel")

Have you ever injured this part of your body before? ☐ YES ☐ NO

Did your injury/illness exposure occur on employer's premises? ☐ YES ☐ NO

Please circle specific affected body part(s).



Describe how the incident occurred. (Ex: "When ladder slipped on wet floor, I fell 20 feet; I was sprayed with chlorine when gasket broke during replacement. or I developed soreness in my wrist over time.)

Describe what you were doing when the incident occurred. (Ex: "I was climbing a ladder responding to a fire in an air conditioner unit that exploded.")	All Equipment, Materials or Chemicals Employee Was Using When Accidnt or Illness Exposure Occurred

Date Disablilty Began	Date Returned to Work	Were Safeguards or Safety Equipment Provided?	YES	NO
		Were They Used?	YES	NO

Physician/Health Care Provider (Name & Address)	Hospital (Name & Address)

Witnesses (Name & Phone #)

Name of Supervisor Notified	Employee Signature	Date

INITIAL TREATMENT

(Check all that apply)

- ☐ No Medical Treatment
- ☐ Minor Treatment by Employer
- ☐ Minor by Clinic or Hospital
- ☐ Emergency Care
- ☐ Hospitalized less than 24 hrs.
- ☐ Future Major Medical Lost Time Anticipated