EMPLOYEE

Incident/Accident Report

Please use this form to document any incident or accident involving a city employee or that occurs on city property. Regardless of the severity of the damage or injury, this form must be filled out completely for all incidents/accidents occurring during work or on city premises. Incident/Accident Reports must be completed within 3 days of occurrence.

To Be Completed by Employee. Please print or type and provide as much detail as possible.
Supervisors may assist employee with this form if necessary.

Employee Name:	**Date of Incident/Accident:**	**Time:**
Employee Department:	**Job Title:**	
Employee Work Phone Number:	**Employee Alternate Phone/Message Number:**	

Where did the incident occur? ***Provide details on where the incident occurred (address or cross streets):***

Who witnessed the incident:	**Witness #1 (Name, phone, address):**	**Witness #2 (Name, phone, address):**

What happened? ***Provide specific details on what happened and how you were injured. (Attach additional pages if more space is required.)***

Was any property damaged in the incident? City property or other private property? ***If yes, please explain:***

ORIGINALS: Human Resources **COPIES TO:** Maintenance & Safety Supervisor, Dept. Safety Committee and Risk Management

Name of injured party or owner of damaged property:	**Name(s) and address(s):**	**Phone Number(s):**

Were police called? Yes / No	**Were fire and rescue called?** Yes / No
Vehicle number or police report number?	**Were photos taken?** Yes / No ***(If yes, please forward photos along with completed Incident/Accident Report).***

Was the accident caused by defective equipment, another person, or during training? ***If yes, please explain:***

What body part(s) were injured or affected? ***Describe your injury and resulting pain. Be specific:***

Have you injured this part(s) of your body previously, or is there any pre-existing condition that could affect the injury? Yes / No / Explain to the right ->	***If yes, please explain:***

On the date of injury/accident what was your normal work shift? **Working shift hours:**	**Working shift days:** **Regular scheduled days off:**	***If work shift varies, please describe:***

What job duties were you performing at the time of your injury? ***Describe the work you were doing when you were injured:***

ORIGINALS: Human Resources **COPIES TO:** Maintenance & Safety Supervisor, Dept. Safety Committee and Risk Management

What could be done to prevent a reoccurrence? ***Provide suggestions for improved training, safety equipment or other ideas that could prevent a reoccurrence:***	
Did you miss time from work? Yes No Comments -->	***Comments:***
Did you see a doctor for your injury? Yes No Comments -->	***Comments:***
 **If you received medical treatment, other than basic first aid, please complete an 801 FORM** *(Report of Job Injury or Illness Workers' Compensation Claim Form).*	
Did you return to regular work? Yes No Comments-->	**If you answered no, were you given restrictions by your treating physician?** ***Describe any restrictions:***

Please note: In the event that a workplace injury requires medical treatment, a return to work authorization from a physician will be **required.** Attach copies of any physician's statements or "Return to work" documents to this report. All documents containing medical details need to be sent to Human Resources for confidential storage.

Employee Signature: _____ **Date:** _____

ORIGINALS: Human Resources **COPIES TO:** Maintenance & Safety Supervisor, Dept. Safety Committee and Risk Management