REPORT OF INCIDENT, ACCIDENT, AND INJURY

Complete information and forward to Human Resources/Risk Management within **24 hours** of incident via fax, e-mail, or hard copy.

SECTION 1: Type of Incident:

☐	Injury	☐	Accident - Vehicle	☐	Near – Miss	☐	Private Property Damage
☐	Injury & Property	☐	Accident Equipment	☐	City/Public Property Damage	☐	

SECTION 2: Employee Information (all field required):

Employee Name		Employee Contact Number	
Employee Position		Department	
Supervisor		Supervisor Contact Number	
Time Employee Began Work		Employment Status (FT, PT)	
Unable to Return to Work		Date Last Worked	

Date of Incident		Time of Incident	
Address/Location			
Person Notified			

SECTION 3: Incident Information

Detailed description of employee's actions at time of incident (how, what, why):

Direct cause(s) of incident:

Were other employees involves? If so provide name(s) and contact number(s):

Witness Name/Telephone Number:

Did the employee receive basic first aid?	☐	Yes	☐	No
Was the employee sent to FOX Occupational Clinic?	☐	Yes	☐	No
Was the employee sent to emergency room?	☐	Yes	☐	No
Name and address of hospital?				
Was employee sent to another occupational clinic?	☐	Yes	☐	No
Name and address of clinic?				
Was treatment refuse?	☐	Yes	☐	No
Comments:				

SECTION 4: Indicate injured body part

☐	Ankle	☐	R	☐	L	☐	Fingers	☐	R	☐	L	☐	Torso	☐	Teeth				
☐	Foot	☐	R	☐	L	☐	Thumb	☐	R	☐	L	☐	Neck	☐	Throat				
☐	Toes	☐	R	☐	L	☐	Hand	☐	R	☐	L	☐	Back - Lower	☐	Mouth				
☐	Knee	☐	R	☐	L	☐	Wrist	☐	R	☐	L	☐	Back - Middle	☐	Nose				
☐	Leg	☐	R	☐	L	☐	Arm	☐	R	☐	L	☐	Face	☐	Internal				
☐	Calf	☐	R	☐	L	☐	Forearm	☐	R	☐	L	☐	Head	☐	Nose				
☐	Thigh	☐	R	☐	L	☐	Elbow	☐	R	☐	L	☐	Heart	☐	Internal				
☐	Hip	☐	R	☐	L	☐	Shoulder	☐	R	☐	L	☐	Teeth						
☐	Buttocks					☐	Ear	☐	R	☐	L	☐	Throat						
☐	Groin	☐	R	☐	L	☐	Eye	☐	R	☐	L	☐	Mouth						
						Other:													

SECTION 5: Indicate type of injury

☐	Abrasion		☐	Compound Fracture		☐	Numbness
☐	Amputation		☐	Crushed		☐	Pain
☐	Bite/Sting		☐	Cut/Laceration		☐	Puncture
☐	Blister		☐	Crushed		☐	Repetitive Motion
☐	Break/Fracture		☐	Dermatitis		☐	Swelling
☐	Bruise/Contusion		☐	Hearing		☐	Splinter
☐	Burn – Chemical		☐	Illness		☐	Sprain/Strain
☐	Chemical Exposure		☐	Loss of Consciousness			
☐	Exposure to						
☐	Other						

SECTION 6: Damage Information (Vehicle/Equipment)

Redlands Police Report Number				
Other Agency		Report or Reference Number		
City Vehicle Identification Number		City License Number		
Make & Model of Vehicle/Equipment				
Extent of damage to equipment/vehicle				
Is the vehicle/equipment out of service?				
If yes, is it:	☐ Temporarily out of service	☐ Permanently out of service		
Where will the repairs be made?	☐ City Garage	☐ Other		
Additional information/comments				

SECTION 7: Corrective Action(s)

What corrective actions have been taken to prevent recurrence?

Employee Signature _____ Date _____

Supervisor Signature _____ Date _____

SUPERVISORS ACCIDENT INVESTIGATION REPORT

This form shall be used by all supervisors assigned to investigate accidents or injuries. Once completed submit this form to Risk Management; retain a copy for the department files.

TO BE COMPLETED BY INVESTIGATING SUPERVISOR

EMPLOYEE NAME:		CONTACT NUMBER:	
JOB TITLE:		DEPARTMENT:	
SUPERVISOR:		CONTACT NUMBER:	

DATE OF INCIDENT:		TIME OF INCIDENT:	
LOCATION OF INCIDENT:			
PERSON NOTIFIED:			

DESCRIBE ACCIDENT:

(What task was the employee assigned? What tools or equipment was being used?)

NAMES(S) OF ANY WITNESSES:

SAFETY GUIDELINES/PROCEDURES:

(Were safety guidelines/procedures in place and used, please describe?)

RECOMMENDATION:

(Recommended preventative action to take in the future to prevent a reoccurrence?)

Supervisor Signature _____ Date _____

Department Head Signature _____ Date _____