 ACCIDENT/INCIDENT REPORT	**To be completed by Supervisor and submitted to HUMAN RESOURCES within 24 hours**	Initial Report

Check Type:

☐ Workers comp. (Claim), complete Sections 1, 2, 5, 6
☐ Liability Claim, complete Sections 1, 4, 5, 6
☐ Property/Equipment (Claim), complete Sections 1, 3, 4, 5,
☐ 6 Motor Vehicle Claim, complete Sections 1, 3, 4, 5, 6

Check Notification:

Notified Police: ☐ Yes ☐ No
Required for all Auto Accidents /Property Damage

Notified Department Designee: ☐ Yes ☐ No
Required for all Auto Accidents /Property Damage

Notified HR: ☐ Yes ☐ No
Required for Accidents

SECTION 1	**BASIC INFORMATION**

Employee/Citizen Name:_______________________ Employee ID Number (if applicable):________________
Department:_______________________ Date of Incident: ________________
Supervisor Name:_______________________ Time of Incident:__________a.m.__________p.m.
Supervisor Phone & Ext.: _______________________ Time Shift Started: ________a.m.__________p.m.
Supervisor Cell Phone: _______________________ Day of Week: ________________
Date Reported to Supervisor:_______________________
Location/Address of Incident:_______________________

SECTION 2.	**WORKERS' COMPENSATION**

Employee's Home Address: _______________________
City:_____________ State:__________ Zip:__________ County:______________
Home Phone:_______________ Phone# where employee can be reached:______________
Treating Doctor (if known) _______________
Clinic/Hospital: _______________________ Phone: ______________
Address: _______________________ City:__________ State: __________ Zip:__________
Nature of Injury:_______________ Cause of Injury: _______________
Part of body injured: _______________
Employee Refused Medical Treatment: Yes No Medical Treatment Received: Yes No
Was there any loss of time? Yes No If yes, date loss of time started: _______________

SECTION 3.	**CITY VEHICLE ACCIDENT/PROPERTY/EQUIPMENT DAMAGE**

Describe damage: ☐

Year ☐ Make: ☐ Model: ☐ VIN: ☐ Vehicle #: ☐
Police called? Yes ☐ ☐ Police report Number: ☐ Vehicle Towed: Yes ☐ No ☐

SECTION 4.	**VEHICLE/PROPERTY DAMAGE (NOT CITY)**

Owner of vehicle/property:_______________________ Driver of Vehicle: _______________
Address or Location: _______________________
City:_____________ State:__________ Zip:__________ County: ______________
Year:__________ Make:__________ Model:__________ Vehicle License Number: ______________
Driver's Insurance Company:_______________________ Policy Number:_______________________

SECTION 5	**COMPLETE FOR ALL ACCIDENTS**

Witness Name, Address, Contact Phone: _______________________
Witness Name, Address, Contact Phone: _______________________

SECTION 6	SUPERVISOR'S INVESTIGATIONREPORT

A. What happened? *Describe what took place or what caused you to conduct thisinvestigation.*

B. Why did it happen? *Get all the facts by studying the job and situationinvolved.*

What Happened?

How and why did it happen?

Who was involved?

C. What have you done thus far? *Take or recommended action, depending upon your authority. Follow up – was action effective?*

D. Alcohol & Controlled Substance Policy:

Employee DrugScreen: ☐ Yes ☐ No

Employee's signature: ______________________ Date: ______________

Supervisor's signature: ______________________ Date: ______________

Leave this area blank to be completed by Human Resources

Did the action(s) of another cause/contribute to the incident? Yes ☐ No ☐. If yes, list:	Was the Accident Caused by any of the below factors:	
	Operator Error: ☐ Yes ☐No	Equipment: ☐ Yes ☐ No
Was personal protective equipment in use? Yes ☐ No☐	Environmental: ☐ Yes ☐No	Weather: ☐ Yes ☐ No
Was a seat belt worn? Yes ☐No☐		