ACCIDENT REPORT
PERSONAL INJURY REPORT

SECTION I (must be completed by injured employee within 24 hours of injury)

Employee: _____ Department: _____

Position: _____ Number of years in this position: _____

Was regular job being performed: ☐ Yes ☐ No
Was safety equipment being used: ☐ Yes ☐ No
Is safety equipment provided: ☐ Yes ☐ No

Exact location of accident (be precise):

Date of Accident: _____ Time: _____

Work being performed (be specific):

Describe what happened: (contributing conditions, equipment, circumstances, or personal actions - how and why did accident occur):

INJURY TYPE:

_____ 10 Back Injury
_____ 20 Bruise/Sprain/Strain
_____ 30 Cuts/Abrasions
_____ 40 Breaks
_____ 50 Eye/Skin Irritation
_____ 60 Thermal
_____ 70 Other (dog bite, etc)
_____ 80 Exposure to Infectious Disease
_____ 90 Exposure to Hazardous Materials

Did you telephone the City's Managed Care Provider: ☐ Yes ☐ No

Was time lost from work? ☐ Yes ☐ No If yes, describe:

Was a physician seen? ☐ Yes ☐ No

What could be done to prevent recurrence? (training, mechanical change, procedure change, etc)

Date _____ Employee's Signature _____

(over)

SECTION II (to be completed by Supervisor)

Comments, additions, or points of disagreement with above: _____

I have reviewed the report and have taken action to correct the situation as follows:

Date corrective action to be completed by: _____

_____
Supervisor's Signature

_____
Date

SECTION III (to be completed by witness)

Name: _____ Department:

Additional comments regarding the above accident:

_____
Witness Signature

_____
Date

Distribution:
Human Resources Manager (original)
Employee's Department Head (copy)

Note to Supervisor: Complete First Report of Injury
Note to Employee: If property damage occurred, complete Property Damage Report