ACCIDENT / INCIDENT REPORT

OFFICE USE ONLY

A/I #

Name _____ Date/Time of Incident _____ Circle one: A.M. P.M.
(Name of employee involved in accident/incident) Date Time

Department _____ Classification _____ Approving Supervisor _____

Check where applicable: ☐ Injury to employee ☐ Injury to private person ☐ Property Damage

Location of Incident: _____ Photos taken ☐ Yes ☐ No

Private Party Involved: _____
Name Address Res. Phone Bus. Phone

Witness to Incident: _____
Name Address Res. Phone Bus. Phone

Give details of incident, describe any damage and/or injury to person:

Person preparing report: _____ Date of Report: _____ Police Report # _____

Employee injury Disposition: Medical Treatment Required ☐ Yes ☐ No

REPORT SHOULD BE FILED WITH THE RISK MANAGER'S OFFICE WITHIN 24 HOURS AFTER THE OCCURRENCE.

FOR OFFICE USE ONLY

Received in Risk Managers office by (Name): _____ Date: _____

Report sent to department safety representative (Name): _____ Date: _____

NOTE: THE DEPARTMENT SAFETY REPORT IS DUE BACK IN THE RISK MANAGER'S OFFICE BY Date: _____

DEPARTMENT SAFETY REPORT

☐ Incident

Employee: _____ Was found ☐ Chargeable ☐ Non-Chargeable

Did employee personally appear before Committee? ☐ Yes ☐ No Time Lost ☐ Yes ☐ No

Estimated cost of damage/replacement $ _____

Justification for above conclusions/recommendation for future prevention:

Name _____ Date _____ Name _____ Date _____

Name _____ Date _____ Name _____ Date _____

PLEASE USE ADDITIONAL PAGES IF MORE SPACE IS NEEDED

CENTRAL SAFETY COMMITTEE

☐ Agree ☐ Disagree Date _____ Incident ☐ Reason: _____

Disciplinary Action Points (if chargeable) _____ Posted CSC File _____