ACCIDENT – INCIDENT REPORT

(A COPY OF THIS REPORT IS NOT AUTHORIZATION FOR MEDICAL TREATMENT)

For Employee use items 1,2,4,5,6,7 For Non-Employees use items 1,2,3,4,5,6,7

1. **ACCIDENT**				
Date of Loss:	Time of Loss: AM PM	Location of Loss: (Be Specific)		
2. **CLAIMANT** (WORKER'S COMPENSATION CLAIMS –injury to County employee in course and scope of employment)				
Name of Employee:	Age:	Occupation & Department:	Part of Body Injured: Type of Injury (i.e. cut, bruise, etc.)	
Address:	City:	State:	Zip Code:	Phone Number: ( )
Does employee wish to seek medical attention: Today? □ YES □ NO A "NO" answer above does not waive the employee's right to request Medical attention at a later date.	If "YES" Designate Referral: (Name of Physician, Clinic, Hospital)		Will Employee require time off from work? □ YES □ NO	
	Date injury first reported:	Time injury first reported:	Return to work date:	
3. CLAIMANT (GENERAL LIABILITY CLAIMS – include Non-County employees and/or property not owned by the County)				
Name of Claimant:	Age:	(a) Part of the body injured and type of injury, or (b) Damaged Property		
Address:	City;	State:	Zip Code:	Phone Number: ( )
4. PROPERTY (County Owned)				
Describe damaged or stolen property:				
	Estimated costs of damage or value of stolen property:			
5. WITNESS(ES):				
Name:	Address:	City & State:	Phone Number: ( )	
Name:	Address:	City & State:	Phone Number: ( )	
6. DESCRIBE ACCIDENT (to be completed by claimant if at all possible)				
DESCRIBE IN DETAIL THE EVENTS LEADING UP TO AND PRECEDING ACCIDENT If additional space is needed please use page 2.				
7. Signatures		Name of Person Describing Accident		
Signature of Claimant:	Date:	Signature of Constitutional Officer/ Department Head: Date:		
Signature of Supervisor:	Date:	Signature of Safety Director:	Date:	

ATTACH ALL LAW ENFORCEMENT REPORTS RELATED TO THIS ACCIDENT/INCIDENT
USE REVERSE SIDE OF THIS FORM FOR DIAGRAM OF ACCIDENT/INCIDENT

6. DESCRIBE ACCIDENT