INTERNAL USE ONLY Claim #: _____

CITY OF _____
EMPLOYEE INCIDENT REPORT

EMPLOYEE NAME: _____

POSITION: _____

DEPARTMENT: _____ DIVISION: _____

INCIDENT DATE: _____

INCIDENT TIME: _____ AM _____PM

REPORT DATE: _____
(If report date is different from incident date, please explain.)

_____

_____

_____

This incident involves:

___ Employee Injury
___ Damage to City Vehicle/Equipment
___ Damage to Private Property/Vehicle
___ Injury to Someone Other Than a City Employee

1. Location of incident_____

2. If injury, (A) What part of your body was injured? _____

   (B) What is the extent of your injury? _____

   (C) Was First Aid administered? ___ Yes ___ No

   (D) Have you requested medical attention? ___ Yes ___ No
   If Yes, to which Physician, Hospital, or other facility are you going or have already gone?

   Physician: _____

   Location: _____

   Telephone Number: _____

3. Explain in detail how this incident occurred. (If more space is needed, attach separate sheet)

_____

_____

_____

_____

_____

_____

4. Was City Equipment/Vehicle involved? ___ Yes ___ No

   If Yes, Unit #: _____ VIN#: _____

   Year, Make & Model of vehicle: _____

5. If damage to City or Private Property/Vehicle, describe the extent of damage:

_____

_____

6. Was a Police Report filed? ___ Yes ___ No
   If Yes, reporting agency: _____ City PD _____ OK Hwy Patrol _____ Other

7. Were you wearing proper safety equipment (if required) at time of incident? __ Yes __ No
   If No, why not? _____

8. Was anyone else involved in this incident? ___ Yes ___ No
   If Yes: Name: _____

   Address: _____

   Telephone Number: _____

9. Did anyone else see this incident occur? ___ Yes ___ No
   If Yes: Name: _____

   Address: _____

   Telephone Number: _____

10. In your opinion, were there any unsafe acts or conditions (including people and/or equipment) that caused this incident? ___ Yes ___ No

    If Yes , please explain: _____

11. In your opinion, how could this incident have been prevented?

_____

_____

_____

_____

I declare under penalty of perjury that I have examined all statements contained herein, and to the best of my knowledge and belief, they are correct and complete. Any Person who commits Workers' Compensation Fraud, upon conviction, shall be guilty of a felony.

Employee Signature: _____

Date: _____

Employee: Turn this form in to your Supervisor

Supervisor: Submit this form along with your report and any witness/co-worker statements to the Personnel Department and your Department Head within 24 hours of your knowledge of this incident.

Reviewed By: _____(Department Head)
_____(Personnel)
_____(City Attorney)
_____(City Manager)

Comments: _____

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