ADMINISTRATIVE SERVICES HUMAN RESOURCES

INJURY/ILLNESS INCIDENT REPORT

#1 Report the incident to your Supervisor immediately.

#2 If you are injured, call HUMAN RESOURCES at 778-5300 for a Workers' Compensation Claims Packet.

INJURED PARTY

☐ **EMPLOYEE** ☐ **VOLUNTEER** ☐ **WORK CREW**

Name _____ Department _____

Job Title _____ Supervisor _____

Incident Date _____ Location _____

Time Began Work _____ ☐ AM / ☐ PM Time of Incident _____ ☐ AM / ☐ PM

Medical Treatment ☐ No ☐ Yes If yes, Health Care Provider _____

Witness(es) _____

What happened? (Describe how the incident occurred, including what, where, when, why, how.)

What was the injury/illness and part of body affected?

☐ Damage to equipment ☐ Damage to property ☐ Damage to vehicle

Please describe damage: _____

If County vehicle involved, follow directions on the Vehicle Accident Check List in vehicle glovebox.

☐ Sheriff Called ☐ Pictures Taken ☐ Citation Issued

If, bloodborne pathogen exposure:
Source Name & Contact Info _____
_____
Exposure Route (eyes, mouth, etc.)_____
Transmission (blood, saliva, etc.)_____
Did source consent to testing? ◯ YES ◯ NO

Signature _____ Date _____

DEPARTMENT

Supervisor Name _____ Supervisor Title _____

What steps will you be taking to investigate and follow-up on this event?

Signature ***(following review by Department Head)*** _____ Date _____

ROUTING: Copy = Department Original = Human Resources ☐ Fac. Mgmt. ☐ Pros. Atty.

INCIDENT # _____ **CLAIM #** _____ *Last updated 05/09/19*