



CITY OF  
**SOUTH  
PORTLAND**

**ACCIDENT/INJURY FIRST REPORT GUIDELINES AND REMINDERS**

**I. PURPOSE**

As stated in the Personnel Policy, all accidents or injuries to City employees arising out of or during the course of employment must be reported to the employee’s supervisor and Human Resource’s Office. All reports must be in writing which can be accomplished by filling out the City’s Accident/Injury First Report. In addition, any vehicle accidents or other accidents causing damage to City property under the direct care and control of a City employee must be reported to their supervisor and the Executive Office. The Executive Office shall also be informed of any injuries or loss of property arising out of or during the course of City events, activities, or City operations.

**II. GUIDELINES**

1. After an Incident - After an incident occurs, employees should ensure that everyone involved is safe. If there are injuries, employees should call 911 for assistance.

For all vehicle accidents where a City vehicle is involved, it is strongly encouraged that employees call the local police department and employees are required to call the local police station for damages estimated to be more than \$1,000. The officer should present the employee with a crash report number that should be included on the Accident/Injury First Report. If under certain circumstances this does not take place, employees may be required to fill out an Automobile Questionnaire and/or answer follow up questions.

If an employee is injured, they should seek medical attention as soon as possible. This may be a band-aid or a visit to the City’s occupational health provider. Employees should check with their immediate supervisor. If the injury is severe and a danger to life, employees should call 911 immediately. Contact information for the City’s workplace occupational healthcare providers are below:

**CONCENTRA (SOUTHBOROUGH DR.)**  
400 SOUTHBOROUGH DR. #1, SOUTH  
PORTLAND, ME 04106  
(207) 761-1100  
M-F: 8:00 AM - 5 PM

**CONCENTRA (WESTERN AVE.)**  
85 WESTERN AVE., UNIT 6, 7, 8, SOUTH  
PORTLAND, ME 04106  
(207) 774-7751  
M-F: 7:30 AM - 5 PM

**BAYSIDE EMPLOYEE HEALTH**  
50 SEWALL ST. # 301, PORTLAND, ME  
04102  
(207) 780-6631  
M-F: 7:30 AM - 5 PM

**It is important to note that contact information for everyone involved is very important. At the very least, employees should note any witnesses (including contact information) or other individuals who were directly affected by the incident.**

2. Filling Out the Accident/Injury First Report - the Accident/Injury First Report must be completed within 24 hours and no later than 48 hours after an incident occurs. Timely reporting is important and required.
3. Post Reports - In some cases, employees may be asked follow-up questions or asked to fill out supplemental forms. To ensure a quick resolution for any claim filed after the initial incident, employees are asked to complete these reports and answer any follow up questions in a timely manner.



# CITY OF SOUTH PORTLAND

**IN OFFICE USE ONLY**

INCIDENT #: \_\_\_\_\_

CLAIM #: \_\_\_\_\_

DATE OF NOTIFICATION: \_\_\_\_\_

## ACCIDENT/INJURY FIRST REPORT

**EMPLOYEES WHO ARE INJURED OR ARE INVOLVED IN AN ACCIDENT SHOULD COMPLETE THIS FORM (NOT FOR PUBLIC USE)**

**COMPLETE ALL SECTIONS THAT APPLY**

**EMPLOYEE INJURY CONTACTS - SEE OCCUPATIONAL ACCIDENT AND INJURY FLOW CHART FOR MORE INFO.**

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50 SEWALL ST. # 301, PORTLAND, ME  
04102  
(207) 780-6631  
M-F: 7:30 AM - 5 PM

If the provider above is not open/available or there is a serious employee injury, call **911** for immediate assistance.

### GENERAL INFORMATION (REQUIRED)

#### DATE, TIME, AND LOCATION

INCIDENT DATE: \_\_\_\_/\_\_\_\_/\_\_\_\_ TIME WHEN INCIDENT OCCURRED: \_\_\_\_:\_\_\_\_ AM [ ] PM [ ]

STREET ADDRESS OR NEAREST INTERSECTION: \_\_\_\_\_

CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_ CITY FACILITY (if applicable): \_\_\_\_\_

SUPERVISOR: \_\_\_\_\_ SUPERVISOR'S EMAIL: \_\_\_\_\_

#### WITNESSES

*This section allows you to document at least three (3) witnesses to the incident. Please provide names AND contact information.*

##### WITNESS 1

NAME: \_\_\_\_\_ PHONE: \_\_\_\_\_

##### WITNESS 2

NAME: \_\_\_\_\_ PHONE: \_\_\_\_\_

##### WITNESS 3

NAME: \_\_\_\_\_ PHONE: \_\_\_\_\_

### MOBILE EQUIPMENT OR VEHICLE (IF APPLICABLE)

#### VEHICLE INFORMATION

*If you were involved in a vehicle accident causing \$1,000 or more in damages, you are REQUIRED to call the nearest police station for assistance. This section is intended for you to provide the City with basic information about the damaged City vehicle as well as information about any other vehicle damaged in the accident.*

CRASH REPORT NUMBER: \_\_\_\_\_

##### CITY VEHICLE

DRIVER NAME: \_\_\_\_\_ PHONE: \_\_\_\_\_

VIN (Last 5 Digits): \_\_\_\_\_ MAKE: \_\_\_\_\_ MODEL: \_\_\_\_\_

DESCRIBE DAMAGES: \_\_\_\_\_

##### OTHER VEHICLE

DRIVER NAME: \_\_\_\_\_ PHONE: \_\_\_\_\_

OWNER NAME: \_\_\_\_\_ PHONE: \_\_\_\_\_

INSURANCE PROVIDER: \_\_\_\_\_ POLICY NUMBER: \_\_\_\_\_

MAKE: \_\_\_\_\_ MODEL: \_\_\_\_\_ PLATE #: \_\_\_\_\_

DESCRIBE DAMAGES: \_\_\_\_\_

**PRIVATE/PUBLIC PROPERTY DAMAGES (IF APPLICABLE)**

PROPERTY INFORMATION

PROPERTY STREET ADDRESS: \_\_\_\_\_  
CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_  
PROPERTY OWNER (IF KNOWN): \_\_\_\_\_  
PROPERTY OWNER PHONE: \_\_\_\_\_ PROPERTY OWNER EMAIL: \_\_\_\_\_

**EMPLOYEE INJURIES (IF APPLICABLE)**

INJURY/ILLNESS INFORMATION

NAME: \_\_\_\_\_ PHONE: \_\_\_\_\_  
JOB TITLE: \_\_\_\_\_ DEPARTMENT: \_\_\_\_\_  
SUPERVISOR NAME: \_\_\_\_\_ WAS THIS AN: INJURY [ ] ILLNESS [ ] NEAR MISS [ ]  
DATE SHIFT STARTED: \_\_\_\_/\_\_\_\_/\_\_\_\_ TIME SHIFT STARTED: \_\_\_\_:\_\_\_\_ AM [ ] PM [ ]  
DID THE EMPLOYEE RETURN TO WORK DURING THE SHIFT WHEN THE INCIDENT OCCURRED? YES [ ] NO [ ]  
WAS FIRST AID PROVIDED?: YES [ ] NO [ ] BY WHOM?: \_\_\_\_\_  
DID THE EMPLOYEE SEEK MEDICAL TREATMENT? YES [ ] NO [ ] IF YES, WHERE? \_\_\_\_\_  
DESCRIBE THE INJURY/ILLNESS: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**NON-EMPLOYEE INJURIES (IF APPLICABLE)**

*If the injured person is under 18, provide their parent/guardian contact information. Injuries resulting from a vehicle accident should also be included here.*

INJURED 1

NAME: \_\_\_\_\_ PHONE: \_\_\_\_\_ Under 18? Yes [ ] No [ ]  
STREET ADDRESS: \_\_\_\_\_ CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_  
Parent or Guardian (if applicable)  
NAME: \_\_\_\_\_ PHONE: \_\_\_\_\_  
STREET ADDRESS: \_\_\_\_\_ CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

INJURED 2

NAME: \_\_\_\_\_ PHONE: \_\_\_\_\_ Under 18? Yes [ ] No [ ]  
STREET ADDRESS: \_\_\_\_\_ CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_  
Parent or Guardian (if applicable)  
NAME: \_\_\_\_\_ PHONE: \_\_\_\_\_  
STREET ADDRESS: \_\_\_\_\_ CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

**BRIEF NARRATIVE OF WHAT HAPPENED (REQUIRED) - USE ADDITIONAL SHEET, IF NECESSARY.**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
FILER'S NAME FILER'S SIGNATURE DATE

PLEASE ATTACH ANY PHOTOS OF DAMAGES TO PROPERTY, EQUIPMENT, OR VEHICLES TO THIS REPORT.

**THIS REPORT MUST BE SUBMITTED DIRECTLY TO ACCIDENT@SOUTHPORTLAND.ORG**