Accident/Injury/Notification and First Report

Check **all** that Apply Employee Injury ☐ Vehicle Accident ☐ Equipment Accident ☐

THIS FORM IS CONFIDENTIAL. MAINTAIN IN A CLOSED CHAIN OF CUSTODY.

1. **Fill out Section A and B** with complete details, (leave no blanks)
2. **Make two copies** of entire form
3. **Give copies to** Department Head and Dept. Safety Personnel
4. **Forward Page 1 to Legal Secretary and Pages 1 & 2 to Human Resources WITHIN 24 Hours or ASAP**

Section A

Please attach extra sheet(s) if additional space is needed.

EMPLOYEE INFORMATION

Who Name: _____ Job title: _____

Department: _____ Tel. #: _____

Name of Supervisor(s) Notified: _____ Date & Time Notified: _____

Please indicate Date & Time Work Shift Started: _____

When Date and Time of Injury: _____

Where Address where injury occurred: _____

Description of injury: _____

Was first aid provided? Yes ☐ No ☐ By whom? _____

Did injured person require further medical care? Yes ☐ No ☐ _____

Did employee return to work? (same day) Yes ☐ No ☐ Date employee returned to work _____

Were there injuries to others? Yes ☐ No ☐ If yes, name(s) _____

Contact information of injured parties: (address, email, phone): _____

VEHICLE ACCIDENT

Name of Driver _____ Date of Accident _____ Time of Accident (A.M./P.M.) _____

Where Address / Location of Accident _____

Responding Police Officer: _____ Police Report Number: _____

City Vehicle Unit #: _____ Year _____ Make _____ Model _____

VIN # _____ Registration # _____

Other Vehicle Year _____ Make _____ Model _____

VIN # _____ Registration # _____

Third Party Name(s) / Address / Contact Info: _____

Medical Were there injuries? (Please check one) Yes ☐ No ☐

If yes, name(s) _____

Contact information of injured party (address, email, phone): _____

Driver's License Information License Number _____

Is driver / operator required to possess a Class B license (CDL): Yes ☐ No ☐

If yes, was driver / operator sent for post-accident drug and alcohol testing? Yes ☐ No ☐ Not required ☐

Where driver was sent: _____ Time: _____

(Note: As soon as practicable following an accident involving a commercial motor vehicle operating on a public road, the driver must be sent for post-accident drug (within 32 hours) and alcohol (within 8 hours) testing if (1) Human Fatality; or (2) Police issue a Citation; or (3) Employer discretion in the event a transit bus operator is involved in an accident, based on facts & circumstances (FTA only)

END of Section A

Section B

Injury/Accident Describe what happened

_____

_____

_____

_____

_____

Witnesses/Contact Information (Name, Address, Phone):

_____

_____

_____

Photos and/or witness statement included via: ☐ attached ☐ email ☐ fax

Cause **Why did it happen?** (Provide details on all factors or conditions which may have caused/contributed to the accident, including equipment, tools, materials, or chemicals being used.) *(Please refer to attached Accident Analysis Worksheet to help determine causation factors.)*

_____

_____

_____

_____

_____

_____

_____

Signatures

Employee Signature:_____ Date:_____

Supervisor Signature:_____ Date:_____

Department Safety Chair _____ Date: _____

Department Head _____ Date: _____

END of Section B

COPY Completed Form for Department Head and Dept Safety Rep. SEND ORIGINAL TO Human Resources

Date Received In Human Resources:_____ **Initialed: Karla Giglio** _____

END of Section B

Incident/Injury/Accident Investigation Form

This form is for Documentation of any investigation. May be shared with Safety personnel, HR director, and others.

Attach Copy of Original First Report of Incident to this Investigation Form

Section C-1

Date of Incident _____ Person(s)/Equipment Involved _____

Section C-2

Who Investigated? Names & Title: _____

_____

Date and time of investigation: _____

Section C-3

Recommended corrective action to prevent recurrence: (i.e., Additional training, install guard or safety device, protective equipment, improve housekeeping, improve design, develop or modify Job Safety Analysis (JSA), additional equipment needed, other):

_____

_____

_____

_____

_____

_____

Section C-4

Corrective action taken by Dept.: **Date taken:** _____

_____

_____

_____

Date submitted to Department Safety Committee: _____

Recommendation(s) of the Department Safety Committee: _____

Section C-5

Signature of Dept. Safety Committee Chairperson: _____ **Date** _____

Signature of Department Head: _____ **Date** _____

Section C-5 Investigation Report presented to

City Safety Coordinator _____ **HR Director** _____ **or Other (please specify** _____

END of Section C