CITY OF CHARLESTON
Report of Incident and Injury

General Information

Employee Name: **Employee No.:**

Department: Select Department **Position:** Select Position

Supervisor: **Incident Date & Time:** Select AM/PM

Address/Location of Incident:

Describe what the employee was doing immediately prior to the incident:

Date & Time Employee Shift Began: Select AM/PM

Incident Details

What equipment, substance or other object caused the incident:

Name of individual(s) first notified:

List the name(s) of any witness*

Incident Date & Time: Select AM/PM

*Attach witness statement for each witness

Check Body Part(s) or Area(s) affected and select right,left, or both, if applicable): (Check all that apply)

- ☐ Ankle Select R, L or B
- ☐ Arm Select R, L or B
- ☐ Chest
- ☐ Elbow Select R, L or B
- ☐ Eye Select R, L or B
- ☐ Face
- ☐ Finger Select R, L or B
- ☐ Foot Select R, L or B
- ☐ Groin
- ☐ Hand Select R, L or B
- ☐ Head
- ☐ Hip
- ☐ Internal
- ☐ Knee Select
- ☐ Leg Select
- ☐ Lower Arm Select
- ☐ Lower Back
- ☐ Lower Leg Select R, L or B
- ☐ Neck
- ☐ Respiratory
- ☐ Shoulder Select R, L or B
- ☐ Thumb Select R, L or B
- ☐ Toes Select R, L or B
- ☐ Trunk Select R, L or B
- ☐ Upper Arm Select R, L or B
- ☐ Upper Back
- ☐ Upper Leg Select R, L or B
- ☐ Wrist Select R, L or B
- ☐ Other (describe below)

Injury Source: (Check all that apply)

- ☐ Automobile Accident
- ☐ Burn
- ☐ Caught In/Under/Between
- ☐ Cut / Puncture / Laceration
- ☐ Electric Shock
- ☐ Equipment Accident
- ☐ Fall
- ☐ Hand Tool(s)
- ☐ Injured by Animal/Insect
- ☐ Machine Injury
- ☐ Material Handling
- ☐ Portable Power Tool(s)
- ☐ Repetitive Motion
- ☐ Slip or Trip
- ☐ Sprain / Strain
- ☐ Struck By/Against/Object
- ☐ Struck By/Against/Person
- ☐ Other (describe below)

Treatment

Medical Treatment: (Check one)

☐ On-site First-aid only ☐ Urgent Care Facility ☐ Emergency Room ☐ Other (describe below)

Name and location of medical facility (enter N/A if employee received no treatment):

Was the employee admitted to the medical facility? Select Yes or No

Preparer's Name (print) **Preparer's Signature** **Date**

Employee's Signature **Date**

By signing above, the employee does hereby authorize any person or persons who have in the past, or will in the future medically amend, treat or examine me or any person who may have information of any kind which may be used to arrive at a decision in any claim for injury or disease arising from the injury/illness described above, to disclose such information to the City, or any individual or entity authorized by the City. A copy of this form shall also serve as an original. **A completed report must be sent to the Safety Coordinator no later than the end of the shift in which the incident/ injury occurred, or as soon as reasonably possible if off-site medical treatment was obtained. Completed forms can be faxed or emailed to (304) 348-8055 or safetycoordinator@cityofcharleston.org.**

Revised 01/05/2017