# Safety Incident Report

Incident Report #:___________________

**EMPLOYEE REPORT**

Employee Name:_____________________________________ Dept:________________________

Employment Agency Worker? ☐ Yes ☐ No If yes, which agency: ___________________

Job Title:________________________________________ Shift Worked: _______________________

When did the incident occur? Date:____________________ Time:_________ a.m. p.m.

Location of Incident?____________________________________________________________

Nature of Injury/Illness/Illness Exposure:

Part of Body Affected: ________________________________ Left Side Right Side

Type of Injury/Illness/Illness Exposure (e.g., strain, cut): ____________________________________

What were you doing just before the incident occurred? ________________________________________

_____________________________________________________________________________

What machinery/equipment were you using? ___________________________________________________

_____________________________________________________________________________

Were you properly trained for the task you were performing at the time of the incident? ☐ Yes ☐ No

Was the incident caused by defective equipment? ☐ Yes ☐ No

If yes, explain:_______________________________________________________________

Describe what happened (PLEASE BE SPECIFIC): ____________________________________________

_____________________________________________________________________________

_____________________________________________________________________________

What do you think can be done to prevent this incident from reoccurring? _________________________

_____________________________________________________________________________

_____________________________________________________________________________

**I choose *not* to seek medical treatment at this time. This does not preclude me from seeking medical treatment at a later date.** ***Signature*** _______________________________________________

If treatment received, check one: ☐ First Aid ☐ EMT Review ☐ Urgent Care ☐ ER Room
☐Physician or Other Health Care Provider ☐ Hospitalized as In-patient

Date Treatment Received:_______________ Dr. Name and/or Clinic: ______________________________

Dr./Clinic Address:_____________________________________________________________

Brief description of treatment (e.g., stitches, injection): __________________________________

List Witness Information: (Address and telephone are not necessary for City of Albany employees)

Witness #1 (Name, Address, Phone): ___________________________________________________

Witness #2 (Name, Address, Phone): ___________________________________________________

When was incident reported? Date:_______________ To Whom: ___________________________________

☐ Check here if Property Damage Report was completed.

*Employee Signature:*_____________________________________ *Date:* ________________________

## SUPERVISOR REPORT

Incident Type *(check one)*: ☐ Injury ☐ Illness ☐ Illness Exposure ☐ Death
☐ Other ______________________________________________

Reported within 24 hours of the incident? ☐ Yes ☐ No

Initial Hours Lost: Medical Treatment _______ Authorized Time Loss ____________________

What was the immediate cause of this incident?

☐ Lack of training ☐ Supervision ☐ Rule Enforcement ☐ Maintenance ☐ Other ____________

Were safe job procedures followed? ☐ Yes ☐ No If no, explain: ____________________

______________________________________________________________

Supervisor Review of Incident: ____________________________________________

______________________________________________________________

______________________________________________________________

______________________________________________________________

Supervisor Findings: ____________________________________________

______________________________________________________________

______________________________________________________________

______________________________________________________________

Specific corrective actions or preventative measures taken: ____________________________

______________________________________________________________

______________________________________________________________

Was incident caused by another person(s)? ☐ Yes ☐ No

If yes, list name(s), address(es), & phone #(s): ____________________________

______________________________________________________________

*Supervisor Signature:*______________________________ *Date:* ______________

*Manager Signature (if applicable):*______________________________ *Date:* ______________

*Department Director Signature:*______________________________ *Date:* ______________

## SAFETY COMMITTEE ANALYSIS

Safety Committee Findings: ____________________________________________

______________________________________________________________

______________________________________________________________

Committee Recommendations: ____________________________________________

______________________________________________________________

______________________________________________________________

*Safety Committee Chair Signature:*______________________________ *Date:* ______________

*Human Resources Signature:*______________________________ *Date:* ______________