JEFFERSON COUNTY, ALABAMA
EMPLOYEE INJURY/INCIDENT REPORT

All injuries, even minor ones, must be reported. Please complete this report in full on the day of injury, if possible, but in no case later than forty-eight (48) hours after the injury. The details and fact of the injury are important to know since this form is used to prevent similar injuries to you and your co-workers.

Part I – To be completed by employee if possible.

NAME____ DEPARTMENT____________________________
Last First Initial Name/Number

HOME ADDRESS____
Street or P.O. Box City State ZIP

BIRTH DATE:____________ GENDER _____Female _____Male SOCIAL SECURITY NUMBER_______________

MARITAL STATUS _____Unmarried (Single, Divorced or Widowed) _____Married _____Separated HIRE DATE_______________

NUMBER OF DEPENDENTS _________ WORK PHONE__________________ HOME PHONE__________________

SHIFT______________ TITLE___________________________________ SUPERVISOR________________________

DATE OF INCIDENT/INJURY_________________ TIME OF INCIDENT/INJURY_______________ AM PM

Describe what you were doing when the incident/injury occurred: How did the injury occur?

Describe the nature and extent of the injury including all parts of the body affected:

Where did this incident/injury occur?
If off premises, where (include address)

Did anyone witness the incident/injury? If so, please provide the witness name, phone number and department number		
Name	Phone Number	Dept. Number
Witness Statement:		

If this incident involves exposure to blood or body fluids or other exposures, you must also complete the "employee blood/body fluid exposure report."

EMPLOYEE'S SIGNATURE____ DATE________________

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Part II – To be completed by the injured employee's supervisor.

Summary of incident/injury investigation:

What actions have you taken to prevent a reoccurrence of this type accident in your work area?

REPORTED TO SUPERVISOR__________________ RISK MANAGEMENT OFFICE NOTIFIED__________________
Date (Call the Risk Management office during business hours) Date

SENT TO: RISK MANAGEMENT OFFICE DOCTOR EMERGENCY ROOM

METHOD OF TRANSPORTATION CAR AMBULANCE OTHER__________________________

NAME AND ADDRESS OF DOCTOR____

WAS THE EMPLOYEE ADMITTED TO THE HOSPITAL? YES NO

If an unsafe condition existed, check all that apply			
	Defective tools or equipment		Slippery or uneven walking surface
	Equipment not properly guarded		Improper warnings
	Poor working conditions		Poor housekeeping
	Other, please describe:		

An unsafe act resulted from, check all that apply			
	Lack of training		Not using safety devices
	Not following rules		Inattention
	Haste / Chance taking		Horseplay
	Improper work method		Improper body position
	Other, please describe:		

Posture of employee, check all that apply			
	Sitting		Driving or riding vehicle or equipment
	Standing		Kneeling or standing
	Lying on ground or floor		Lifting or reaching
	Other, please describe:		

Supervision, check all that applies					
	Directly supervised		Indirectly supervised		Not Supervised

EMPLOYEE WAS WORKING (check one) ALONE WITH CREW OR FELLOW WORKER

_______________________________ _______________________________
Supervisor's Signature Department Head's Signature (optional)

_______________________________ _______________________________
Risk Management Signature Date Received

COMPLETE FRONT AND BACK OF FORM Revised 10/1/2007