Safety Incident Report

Incident Report #:_____

EMPLOYEE REPORT					
Name:		Dept:			
For Fire Dept. only: Worksite Location:	Station ☐ 11 ☐ 12 ☐ 13 ☐ 14 ☐ 15				
Employment Agency Worker:	☐ Yes ☐ No	If yes, which agency:			
Job Title:		On incident date, time you began work:		☐ a.m.	☐ p.m.
When did the incident occur? Date:		Time:		☐ a.m.	☐ p.m.
When was incident reported? Date:		To Whom:			
Location and/or address of incident?					
Nature of injury/illness/illness exposure:					
Part of body affected:		☐ Left Side	☐ Right Side		
Have you previously injured or sought treatment for this body part?		☐ Yes	☐ No		
Describe the injury/illness/exposure specifically (e.g., strain, sprain,					
Describe the events leading up to the incident:					
What machinery/equipment were you using (if any):					
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 can be done to prevent this type of incident from reoccurring:					
List witness information: (address and telephone are not necessary for City of Albany employees)					
Witness #1 (Name, address, phone):					
Witness #2 (Name, address, phone):					
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):					
Are you filing a worker's compensation claim at this time?	☐ Yes ☐ No				
Employee Signature:		*Date:*			

SUPERVISOR REPORT

Incident type *(check one)*:	☐ Injury ☐ Illness Exposure ☐ Other (please describe): ☐ Illness ☐ Death		
Is this incident OSHA recordable?	☐ Yes ☐ No	Reported within 24 hours of the incident?	☐ Yes ☐ No
# of initial hours for:	Medical treatment		Authorized time loss

[required written note by your treating physician]

What was the most serious result for the employee?

☐ Fatality ☐ Days away from work - How many? ☐ Job transfer/restriction ☐ Other

Categorize the immediate cause of this incident:

☐ Lack of training ☐ Supervision ☐ Rule enforcement ☐ Maintenance ☐ Other

Were safe job procedures followed? ☐ Yes ☐ No

Supervisor review of incident:	
Supervisor findings:	
Specific corrective actions or preventative measures taken:	

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

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

# of days worked per week by employee:		# of hours worked per shift by employee:	
Worker's regular shift:	(from) ☐ a.m. ☐ p.m. (to) ☐ a.m. ☐ p.m.		

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:*

ADDITIONAL REPORT INFORMATION (continued)

The space below may be used to provide additional Employee Report and/or Supervisor Report details. Please label clearly the report section associated with each comment. If this space is not used, it is not necessary to print/file this page.