City of Miami

REPORT OF INCIDENT / PROPERTY DAMAGE / INJURY

INSTRUCTIONS:

1. This form must be completed by the supervisor of the area where the incident occurred as soon as possible **on the same day** of the incident.
2. **DO NOT** use this form to report employee injuries. Use the appropriate SUPERVISOR'S REPORT OF EMPLOYEE ACCIDENT / INJURY form.
3. **DO NOT** use this form to report vehicle collisions. Use the SUPERVISOR'S VEHICLE COLLISION ACCIDENT / PROPERTY DAMAGE / PERSONAL INJURY REPORT.
4. **DO NOT** use this form for visitors that sustain an accident/injury in a City of Miami park. Use the Parks Dept. VISITOR ACCIDENT / INJURY REPORT FORM.
5. The claims network must be contacted at 1-877-647-4545 within 24 hours of occurrence.

Person Involved in Incident

Name of Individual: (include middle initial) | D.O.B. (MM/DD/YYYY):

Address:

Telephone: | Gender: ❑ Male ❑ Female | Is the person involved a City of Miami employee? ❑ YES ❑ NO

Location of Occurence

Date of Incident (MM/DD/YYYY): | Time of Incident : ❑ AM ❑ PM | Check one: ❑ No Injury ❑ Personal Injury ❑ Property Damage

Previous injuries? ❑ YES ❑ NO | Exact Location of Incident : | Name of Dept./City Facility:

Specific location where incident occured:

List the names of any witnesses and contact info (if available):

Name: _____ Contact #: _____ Name: _____ Contact #: _____

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Type of Incident (check one):

- ❑ Aggressive/Violent Person
- ❑ Bomb Threat
- ❑ Chemical Exposure
- ❑ Electrical Discharge/Short-circuit/Overload
- ❑ Fire/Explosion
- ❑ Gas Leak
- ❑ Hazardous Condition
- ❑ Illness
- ❑ Near Miss Accident
- ❑ Potential Health Exposure
- ❑ Property Damage/Vandalism
- ❑ Robbery/Assault
- ❑ Slip/Fall
- ❑ Suspicious Person
- ❑ Suspicious Substance
- ❑ Vehicle Damage
- ❑ Other (please explain in Incident Details)

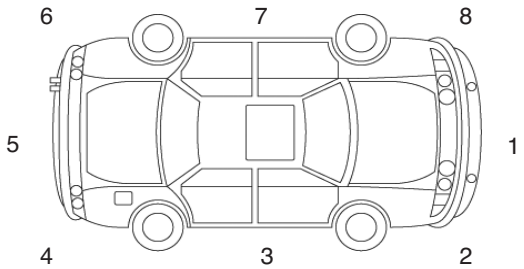
Action Taken (If any): _____

Incident Details

List specific damages: _____

Vehicle Information (if applicable)

Circle number areas of vehicle damage:



Was first-aid rendered? ❑ YES ❑ NO If yes, specify type rendered and by whom: _____

Was injured transported to facility? ❑ YES ❑ NO If yes, list facility name and means of transport: _____

Was the claims network contacted? ❑ YES ❑ NO If yes, date: _____ Case #: _____

Supervisor Name: (print): _____ Spvs. Sgn.: _____ Tel. #: _____ Date: ____ | ____ | 20____

Employee Name (print): _____ Employee Signature: _____ Date: ____ | ____ | 20____

Distribution: **White** - Dept. Employee File; **Canary** - Safety Officer (Risk Management); **Pink** - Risk Management.