CITY OF MARLBOROUGH

NOTICE OF EMPLOYEE ACCIDENT

This form must be submitted to Personnel within 24 hours after an accident which results in an injury.

PLEASE PRINT OR TYPE

DEPARTMENT:____ DATE OF THIS REPORT: ___________________

Injured Person

Name of injured: ____ SS#:____________________________
(First Name) (Initial) (Last Name)

Address: No and St.:___________________________________ City/Town: ________________ State: _______

Check (X) Married: ___ Single: ___ Widowed: ____ Widower: ___ Divorced ___ Male: ___ Female: ___

Date of Birth:_______________________________

(a) Occupation when injured ___________________ (b) Was this his or her regular occupation: _____________

(If not, state in what department or branch of work regularly employed):__________________________________

(a) How long employed __________________________

(b) No, hours worked per day ______________________________ Wages per day $______________________

(c) No. days worked per week: _________________________ Average weekly earnings $__________________

Time And Place

Place where injury occurred_________________ State if injury occurred on or off employer's premises _______

Date of injury ____________ 20_______. Day of week:_____________ Hour of day _______ AM _______ PM

Date disability began _____________ 20_______ _________A.M. __________ PM.

Was injured paid in full for this day?____

To whom and when was injury reported: ____

Title:____

Cause Of Injury

Machine, tool or thing causing injury:____

Kind of power (hand, tool, electrical, steam, etc.) ____

Part of machine on which accident occurred: ____

(a) Was safety appliance or regulation provided ____________________ (b) was it in use at time: ___________

Was accident caused by injured's failure to use or observe safety appliance or regulation:__________________

Describe fully how accident occurred and state what employee was doing when injured: ___________________

____

____

Names and addresses of witnesses: ____

____

Nature Of Injury

Nature of Injury and Body Part Affected: ____

____

Probable length of disability:____________________________ Has injured returned to work: _______________

If so, date and hour: __________________________ At what occupation: ______________________________

Name and address of physician: ____

Name and address of hospital: ____

Did Employee Die: ____

Signed: ____ Title: _________________________
NAME:
(Injured Person should complete and sign this section)

☐ **CHECK HERE IF THIS IS A MOTOR VEHICLE ACCIDENT. POLICE REPORT MUST BE ATTACHED.**

SUPERVISOR'S ACCIDENT INVESTIGATION REPORT

PLEASE PRINT OR TYPE
THIS FORM MUST BE COMPLETED AND SENT TO: **PERSONNEL DEPT., CITY HALL, 140 MAIN STREET,**
WITHIN 24 HOURS AFTER AN ACCIDENT.

PART I – GENERAL INFORMATION DATE OF THIS REPORT: ____________________

NAME OF EMPLOYEE: ____ DEPT: ______________________

DATE OF ACCIDENT: _________________________ TIME _____________ AM / PM

EXACT LOCATION: ____

JOB ACTIVITY AT TIME OF ACCIDENT: ____

PART II – DESCRIPTION OF ACCIDENT (WHAT HAPPENED?)

____

____

____

PART III – THE CAUSE OF THE ACCIDENT

A. DESCRIBE UNSAFE ACTS: ____

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____

____

B. DESCRIBE UNSAFE CONDITIONS: ____

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____

PART IV – CORRECTIVE ACTIONS (WHAT ACTION HAS BEEN TAKEN OR WILL BE TAKEN TO CORRECT THE UNSAFE ACT AND/OR UNSAFE CONDITION)

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____

PART V – REMARKS

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____

REVIEWED BY
DEPARTMENT HEAD: ______________________________ SIGNED: ____________________________________
SUPERVISOR:

FIRE & POLICE DEPARTMENTS: ______ ORIGINAL TO PERSONNEL DEPT. _______ COPY TO LEGAL DEPARTMENT

NOTE: THIS FORM DOES NOT TAKE THE PLACE OF THE REGULAR ACCIDENT REPORT REQUIRED BY THE INDUSTRIAL ACCIDENT BOARD. (USE OTHER SIDE IF ADDITIONAL SPACE IS REQUIRED.)