

# Carroll County Incident Report

Office of Risk Management 410-386-2082 ~ 410-848-0003 (fax)

Incident Date:	Incident Time: AM <input type="checkbox"/> PM <input type="checkbox"/>	Date Reported to Risk Mgt.:
Location of Incident:		Department:
Describe Incident:(Include equipment, materials, environment and anyone involved)		
Witnesses: Y <input type="checkbox"/> N <input type="checkbox"/> Witness: Name / Address or Position / Department / Phone		
1.		
2.		
<b>Incident Type (Check all that apply)</b>		
Auto - County <input type="checkbox"/>	Property/Equipment - County <input type="checkbox"/>	Personal Injury - Employee <input type="checkbox"/>
Other <input type="checkbox"/>	Other <input type="checkbox"/>	Other <input type="checkbox"/>
<b>County Vehicle</b>	<b>County Property</b>	<b>Employee Information</b>
County Vehicle #	Describe Property	Name
Driver		Position
Passenger(s)		Department
Yr/Make/Model		Shift Started
Road Conditions		Medical Treatment Y <input type="checkbox"/> N <input type="checkbox"/>
Rate of Speed	Describe Damage	Where:
Describe Damage		Returned to Work Y <input type="checkbox"/> N <input type="checkbox"/>
		Describe Injury (Body Part)
<b>Other Vehicle</b>	<b>Other Property</b>	<b>Other Injured</b>
Driver	Owner	Name
D/L #	Address	Address
Address	Phone #	Phone #
Phone	Insurance	Medical Treatment Y <input type="checkbox"/> N <input type="checkbox"/>
Tag #	Phone #	Where:
Yr/Make/Model	Policy #	Describe Injury (Body Part)
Insurance Co	Describe Property and Damage	
Phone #		
Policy #		
Passenger(s)		
Describe Damage		
Police Called Y <input type="checkbox"/> N <input type="checkbox"/> Report #		Ambulance Called Y <input type="checkbox"/> N <input type="checkbox"/>
I agree with the above description of the incident:		
Supervisor Signature and Date		Employee Signature and Date

## Incident Investigation

*To be completed by the supervisor*

Is there a diagram of the accident? Y <input type="checkbox"/> N <input type="checkbox"/> If yes, please attach		
Were photos of the damage taken? (Recommended) Y <input type="checkbox"/> N <input type="checkbox"/> If yes, please attach and email.		
Were the employee(s) involved acting within scope of employment? Y <input type="checkbox"/> N <input type="checkbox"/> If no, describe:		
Were unsafe conditions present that contributed to the incident? Y <input type="checkbox"/> N <input type="checkbox"/> If yes, describe		
Did weather contribute to the incident? Y <input type="checkbox"/> N <input type="checkbox"/> If yes, describe:		
What safety equipment was used?		
Was the safety equipment being used properly? Y <input type="checkbox"/> N <input type="checkbox"/> If no, describe:		
As the supervisor, what are your recommendations to prevent this type of incident from occurring again? Be specific – think what, why, when, where, who and how:		
I agree with the above description of the incident and recommendations:		
Supervisor Signature and Date	Employee Signature and Date	
<b>For use by ORM:</b> Auto Liability <input type="checkbox"/> Auto Comp/Collision <input type="checkbox"/> Property <input type="checkbox"/> GL <input type="checkbox"/> W/C <input type="checkbox"/> Incident Only <input type="checkbox"/>		
LGIT Claim #	WC Claim #	Date Received
Page 2 of 2		