EMPLOYEE INCIDENT/ACCIDENT REPORT

Instruction: Complete immediately and submit to Risk Management (RM) within **24 hours**. Hand deliver or Email <u>dcoughenour@flagstaffaz.gov</u> and <u>mdupuy@flagstaffaz.gov</u> or fax to 928 226 0123

| Employee Involved: (Last, First, MI) | | Date and Time (AM/PM) of Accident: | | |
|--|-------------------------------|------------------------------------|--------------------------|--|
| Date Supervisor Notified: | Risk Management notifiedYesNo | at the time of the accident? | Department: | |
| Length of time in position: | Circle one: INFO ONLY | / FIRST AID / MEDICAL | Name/Title of witnesses: | |
| Job Title: | Accident Location: | | Shift begins/ends: | |
| Describe in <u><i>detail</i></u> how the accident occurred: (If additional space is needed, continue on a separate page.) | | | | |
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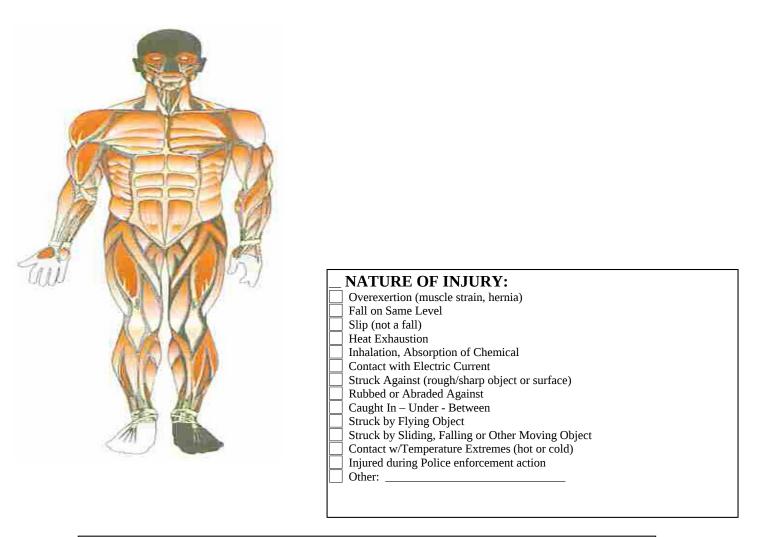
• Please CIRCLE each injured area of the body

• Please check "FRONT" or "BACK"

BODY PART INJURED: NATURE OF INJURY:

| Skull | Shoulder | Abrasion |
|-------------|----------------|---|
| Ear(s) | Upper Arm | Bruise |
| Eye(s) | Elbow | Burn |
| E Face | Forearm | Foreign Body in Eye |
| 🗌 Neck | Wrist/Hand | Fracture |
| Other: | Finger(s) | Loss of Consciousness |
| Hips | Back | Laceration/Amputation |
| 🗌 Upper Leg | Chest | Puncture Wound |
| Lower Leg | Abdomen | Absorption/Inhalation |
| Knee Knee | Groin | Crushing Injury (i.e. fingers or |
| Ankle | Other: | hand caught in or between) Muscle Strain/Sprain |
| Foot | | Other: |
| | | |





| THIS PAGE IS TO BE COMPLE | TED BY THE | EMPLOYEES SUPERVISOR |
|--|------------|----------------------|
| Is the validity of the injury in question? | Yes | No |
| Employee provided first aid? | Yes | No |
| Employee requested medical care? | Yes | No |
| Caused by Non City personnel? Who? | Yes | No |
| Employee contact Risk after treatment? | Yes | No |
| Did employee return to work same day? Yes No | | |
| Type of first aid received: | | |
| Medical facility used: | | |
| Light duty available in the department? | Yes No | N/A |

CAUSE(S) Based on Investigation; Mark ALL Appropriate Boxes below

UNSAFE ACTS:

HAZARDOUS CONDITIONS:

Unsafe Loading/Lifting/Carrying

Inadequate VentilationImproper Lighting

| Failure to Use Personal Protective Equipment | Slippery Work Surface | | |
|--|---|--|--|
| Using Defective and/or Broken Equipment/Machine/Tool | Improperly Guarded Equipment/Machine/Tool | | |
| Defeating Safety Device / Machine Guard | Defective Equipment /Machine/Tool | | |
| Operating Equipment/Machine/Tool without Authority | Poor Housekeeping | | |
| Machinery in Motion – Adjusting, Clearing Jams, Cleaning | Improper Dress or Apparel (i.e. wearing jewelry) | | |
| Operating at Unsafe Speed | Contact with Harsh Chemicals or Skin Irritants | | |
| Failure to Warn Others | Unsafe Design or Construction | | |
| Horseplay (distracting, startling, teasing other associates) | Unsafe Work Procedure or Work Practice | | |
| Failure to observe proper or established safety procedures | Hazardous Weather (High Wind, Lightening, Rain, Hail) | | |
| Inattention | Combative Citizen | | |
| Other: | Other: | | |
| NO UNSAFE ACT(S) | NO HAZARDOUS CONDITION(S) | | |
| What corrective ACTION is planned? By Whom? | | | |
| | | | |

| What is the corrective action completion Date: | | |
|--|-------|--|
| Supervisor's Signature: | Date: | |
| | | |
| Employee's Signature: | Date: | |

Failure to promptly report an injury or incident may result in the denial of the claim.

ORIGINAL TO Risk Management; MAKE COPY FOR SUPERVISOR