

TOWN OF DAVIE EMPLOYEE'S REPORT OF INJURY

Department: _____ **Division/Unit:** _____ **Position Title:** _____

<p>NAME (FIRST, MIDDLE, LAST) _____</p> <p>ADDRESS WHERE I REPORT TO WORK: _____</p> <p>_____</p> <p>WORK TELEPHONE NUMBER _____ SOCIAL SECURITY NUMBER _____</p> <p>Shift / Work Assignment At Time of Injury: _____</p> <p>DATE OF BIRTH _____ SEX _____</p>	<p>DATE OF INJURY (Month / Day / Year) _____ TIME OF ACCIDENT _____ AM PM</p> <p>PLACE WHERE INJURY OCCURRED _____</p> <p>_____</p> <p>TYPE INJURY OR ILLNESS and PART OF BODY AFFECTED _____</p> <p>_____</p> <p>Do You Need Medical Assistance ? YES NO</p>
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EMPLOYEE: Describe fully what you were doing when you were injured and how your injury occur: _____

What personal Protective Equipment were you using? _____

Name Witness(es): _____
(Include Phone Numbers If Not Co-Employees)

Any person who knowingly and with intent to injure, defraud, or deceive any employer or co-employee, insurance company, or self-insured program, files a statement of claim containing any false or misleading information is guilty of a crime. I have reviewed, understand and acknowledge all the above.

Employee Signature: _____ Date: _____

SUPERVISOR'S INVESTIGATION OF EMPLOYEE ACCIDENT / INJURY

To whom was injury/illness reported? _____ Date First Reported: _____

Supervisors description of how injury occurred: _____

Was Employee using issued *Personal Protective Equipment*? Yes No PPE for Job is: _____

Was Employee following *Safe Work Rules and/or Procedures*? Yes No Explain: _____

What actions of the *employee* contributed to this accident? _____

What actions of *other employees* contributed to this accident? _____

What unsafe *physical conditions* contributed to this accident? _____

Describe recommendations for the prevention of Future such Incidents (include any actions already taken): _____

Was the employee sent off-site for medical care? Yes No Where? _____

Has Employee Returned- To-Work? Yes No Full Duty - Restricted Duty - Sent Home By Doctor

Date Returned to Work: _____ or Date Expected To return to work: _____

I have inspected the scene of the injury. Yes No Explain: _____

Investigation Completed By: _____ Date: _____

Supervisors Signature

Reviewed By Department Head: _____ Date: _____

Department Heads Signature

Submit this form to Risk Management