Mark A. Hackel
County Executive

# Employee Incident Report Form

FORM MUST BE FILLED OUT COMPLETELY

** Form should be filled out by injured employee. If injured employee is unable to fill out form within specified time period, the immediate supervisor should fill it out to the best of his/her ability. Please use your discretion.**

☐ Check box if completing form FOR injured employee

## Section 1: EMPLOYEE INFORMATION

Employee Name: _____ Date of Birth: _____

Home Address: _____ Telephone Number: _____

Job Title: _____ Department: _____ Employee ID #: _____

Check All That Applies: ☐ Full Time ☐ Part Time ☐ Temporary ☐ Contract Employee

## Section 2: INCIDENT INFORMATION

Incident Date: _____ Time of Incident: _____ ☐am ☐pm Time Shift Began: _____ ☐am ☐pm

Incident Reported to: _____ Date/Time Incident Reported: _____

Part of Body Injured (specific): _____

Type of Accident:

☐ Slip/Trip/Fall ☐ Extreme Temperature ☐ Repetitive Motion ☐ Material Handling

☐ Cuts/Sharps ☐ Striking an Object ☐ Abrasion/Bruise ☐ Blood Borne Exposure

☐ Other: _____

Injured on County Property: ☐ Yes ☐ No (Specify Address) _____

Incident Location (i.e. lobby, hallway, etc): _____

Action Taken: ☐ First Aid ☐ Employer Clinic ☐ Hospital (Specify) _____

# of Employees Involved: ____ # Injured/Ill: ____ # Fatalities: ____

How Did the Incident Occur. List safety equipment in use (if any) and specifics as to how the injury occurred. Attach photos, sketches, and/or second page if necessary.

_____

_____

_____

_____

_____

FORM MUST BE FILLED OUT COMPLETELY **Employee Name:** _____

## Section 3: WITNESS INFORMATION (If, any)

Witnesses (Name & Phone Number): _____

**WITNESS (If Any) Please Fill Out Supplemental Witness Form**

## Section 4: CORRECTIVE ACTIONS (To be filled out by immediate supervisor)

What Action Can Be Taken to Prevent Incident Reoccurrence?

- ☐ Equipment/Machinery Modification or Maintenance
- ☐ Improve Design/Construction
- ☐ Change to Work Procedure
- ☐ Improve Housekeeping
- ☐ Improve Work Organization
- ☐ Improve Personal Protection
- ☐ Enhance Training and Instruction
- ☐ Use of Safer Material
- ☐ Re-Training
- ☐ Other: _____

Specify Measures Already Taken: _____

Comments: _____

_____

_____

## Section 5: SIGNATURES

Name of Immediate Supervisor (Printed): _____ Phone #: _____

Signature of Immediate Supervisor: _____ Date: _____

Name of Department Head (Printed): _____ Phone #: _____

Signature of Department Head: _____ Date: _____

### AUTHORIZATION FOR PATIENT RECORDS

I, the undersigned, do hereby authorize by my signature on this injury and illness report, any hospital, physician, or other person who has attended me or examined me regarding the injury/illness described above to furnish the Macomb County, or its representative, any and all information with respect to this injury/illness and medical history, consultation, prescription, or treatment, and copies of all hospital or medical records of prior injuries/illnesses similar to this one. A photostatic copy of this Authorization shall be considered as effective and valid as the original.

Signature of Employee: _____ Date: _____

Please immediately scan and email these documents to: employeeincidentreport@macombgov.org or fax them to (586)469-6974 **and** forward the originals via interoffice mail to Human Resources and Labor Relations.

These forms must be returned IMMEDIATELY after completion or within 24 hours of the Incident/Injury/Illness.

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County Executive

# Employee Incident Witness Form

PLEASE FILL OUT AS COMPLETELY AS POSSIBLE

## Section 1: WITNESS INFORMATION

Witness Name: _____

Do you work for Macomb County: ☐ Yes (Specify Department) _____ ☐ No

## Section 2: INCIDENT INFORMATION

I ☐ WAS or ☐ WAS NOT in the near vicinity of the incident when it happened. If near vicinity, list names of those persons you actually saw in the vicinity at the time of the occurrence.

_____

_____

_____

If you were not in the area when the incident occurred, but in another pertinent area, please give your location and the names of persons you saw, or believe were present, in your area.

_____

_____

_____

Are you the supervisor of the injured employee? ☐ Yes ☐ No

Give a factual statement of your actions and observations, before, during, and following the incident. Be as specific as possible.

_____

_____

_____

_____

_____

## Section 3: SIGNATURES

Witness Name (Printed): _____

Witness Signature: _____ Date: _____

Witness Phone Number: _____

Please immediately scan and email these documents to: employeeincidentreport@macombgov.org or fax them to (586)469-6974 **and** forward the originals via interoffice mail to Human Resources and Labor Relations.

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