HURON COUNTY INCIDENT REPORT (attach add'tl sheets as needed)

(To be used for all accidents or incidents involving employees, citizens, or patrons.)

Please PRINT or TYPE

Circle all that apply: *Employee; Citizen; Patron; County Vehicle; County Equipment: County Real Estate; Private Real Estate; Injury; Illness*

(To be completed by employee unless physically unable.)

Date of Incident: _____ Time of Incident: _____ AM/PM

Location of Incident: _____

Name of Employee: _____ SSN # last four only xxx-xx-_____

Name of Employer or Department: _____

Name of Supervisor: _____

Witnesses: _____ _____

Name Best contact Information

Witnesses: _____ _____

Name Best contact Information

Describe the Incident and how it occurred:

_____

_____

_____

_____

Describe injuries or illness, if any, including parts of the body (e.g. right elbow, left upper thigh):

_____

_____

Describe treatment (e.g. Industrial Health Clinic, Emergency Room, EMS, First Aid)

_____

_____

(To be completed by Supervisor)

Date & Time Informed of the Incident: _____ By Whom: _____

What caused the incident? _____

_____

What could have prevented the incident? _____

_____

Did you investigate this incident? Yes ___ No: ___

VEHICLE ACCIDENT – ADDITIONAL INFORMATION NEEDED
Law Enforcement Must be Notified!

Vehicle Damaged: Yes ___ No ___ County ___ Private ___ Other ___

Injuries: Driver ____ Passenger ____ Other ____ Seatbelt(s) worn? _____

Non-county vehicle license #, year, make, model: _____

_____

Non-county driver's name, address, phone #, driver's license #: _____

_____

County vehicle license #, year, make, model: _____

_____

County driver's name, address, phone #, driver's license #: _____

_____

Names of Injured Party(ies):	Names of Witness(es):
_____ Name	_____ Name
_____ Address & Phone	_____ Address & Phone
_____ Name	_____ Name
_____ Address & Phone	_____ Address & Phone

ANY ACCIDENT OR WORK-RELATED ILLNESS OCCURRING DURING WORKING HOURS MUST BE REPORTED TO THE EMPLOYEE'S SUPERVISOR IMMEDIATELY. SUPERVISOR MUST, IN TURN, NOTIFY THE APPOINTING AUTHORITY. THIS REPORT MUST BE FORWARDED TO THE DIRECTOR OF HUMAN RESOURCES AND LOSS PREVENTION WITHIN 24 HOURS OF THE INCIDENT.

The information I have provided either in my own writing or verbally for the purpose of this form is true and correct. I understand that providing false or misleading information or omission of information on this report or any other form relating to this claim if involving injury or illness may result in disciplinary action, up to and including termination of my employment. Failure to complete this form or other forms relating to this claim and submit it in a timely fashion may result in non-certification of a Workers' Compensation claim.

Signature of Employee: _____ Date: _____

Signature of Supervisor: _____ Date: _____

Printed Name of Employee: _____

Printed Name of Supervisor: _____