

DUTCHESS COUNTY SELF INSURANCE PLAN Supervisors Report Of On The Job Injury/Incident

Name _____ Social Security No. _____ Sex: M F
 Home Address _____ Home Phone () _____
 City/Town _____ State _____ Zip Code _____ Date of Birth _____
 Employer/Municipality _____ Date of Hire _____ Job Title _____
 Dept. No. _____ Dept. Name _____ Business Phone _____

Date of Incident / / Time : am pm Time employee began work shift : _____
 Incident Location (including address) _____

 What was employee doing before incident and description of incident (including tasks / duties being performed) _____

 If auto accident, did you report it to: Risk Management ___ NO ___ YES and Auto Center ___ NO ___ YES
 Accident type (ie: slip or fall, lifting, struck by) _____
 Nature of injury (ie: sprain/strain, puncture, contusion) _____
 Part of body affected (ie: neck, right arm, left leg) _____
 Was equipment involved? NO YES If Yes, What _____
 Witness(es) NO YES If Yes, Identify Name(s) _____
 Address _____ Telephone _____
 Was Medical Treatment Provided: NO YES If Yes, When _____
 By Whom: (hospital / doctor) _____

IDENTIFY UNSAFE ACT OR UNSAFE CONDITION THAT CONTRIBUTED TO INCIDENT:

- | | |
|--|---|
| <input type="checkbox"/> Unsafe act committed by injured employee | <input type="checkbox"/> Unsafe condition caused by injured employee |
| <input type="checkbox"/> Unsafe act by other than injured employee | <input type="checkbox"/> Unsafe condition caused by other than injured employee |
| <input type="checkbox"/> No unsafe act | <input type="checkbox"/> No unsafe condition |

Unsafe Acts	Unsafe Conditions	Corrective action taken
_____	_____	_____
_____	_____	_____
_____	_____	_____

DID EMPLOYEE RETURN TO WORK THE NEXT SCHEDULED WORK DAY: NO YES

Supervisor completing report (please print) _____ Phone No. _____

Signature of Supervisor _____ Date _____

I have reviewed this report and understand that I can submit comments on a separate piece of paper.

Signature of Employee _____ Date _____