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)*

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:

❑ Unsafe act committed by injured employee ❑ Unsafe condition caused by injured employee

❑ Unsafe act by other than injured employee ❑ Unsafe condition caused by other than injured employee

❑ No unsafe act ❑ 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 _____