JEFFERSON COUNTY, ALABAMA
EMPLOYEE INJURY/INCIDENT REPORT

All injuries, even minor ones, must be reported. Please complete this report in full on the day of injury, if possible, but in no case later than forty-eight (48) hours after the injury. The details and facts of the injury are important to know since this form is used to prevent similar injuries to you and your co-workers.

PART I – To be completed by employee, if possible.

NAME: _____ DEPARTMENT: _____
Last First Initial Name/Number

HOME ADDRESS: _____
Street or P.O. Box City State Zip

BIRTH DATE _____ GENDER ___ Female ___ Male SOCIAL SECURITY NUMBER _____

MARITAL STATUS__ Unmarried (Single or Divorced or Widowed) ___ Married___ Separated HIRE DATE_____

NUMBER OF DEPENDENTS_____WORK PHONE _____HOME PHONE _____

SHIFT _____ TITLE _____ SUPERVISOR _____

DATE OF INCIDENT/INJURY _____ TIME OF INCIDENT/INJURY _____AM / PM

Describe what you were doing when the incident/injury occurred: How did the injury occur?

Describe the nature and extent of the injury including all parts of the body affected:

Where did this incident/injury occur?
If off premises, where (include address)

Did anyone witness the incident/injury? If so, please provide the witness name, phone number and department number		
Name	Phone Number	Dept. Number
Witness Statement:		

If this incident involves exposure to blood or body fluids or other exposures, you must also complete the "employee blood/body fluid exposure report."

EMPLOYEE'S SIGNATURE _____ DATE _____

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PART II – To be completed by the injured employee's supervisor

Summary of incident/injury investigation:

What actions have you taken to prevent a reoccurrence of this type accident in your work area?

REPORTED TO SUPERVISOR _____ OCCUPATIONAL HEALTH NURSE NOTIFIED _____
Date (Call the Occupational Health Nurse in your area during business hours) Date

SENT TO OCCUPATIONAL HEALTH NURSE _____ DOCTOR _____ EMERGENCY ROOM _____
(Only if life threatening)

METHOD OF TRANSPORTATION: CAR _____ AMBULANCE _____ OTHER _____

NAME AND ADDRESS OF DOCTOR _____

WAS THE EMPLOYEE ADMITTED TO THE HOSPITAL? YES _____ NO _____

If an unsafe condition existed, check all that apply			
	Defective tools or equipment		Slippery or uneven walking surface
	Equipment not properly guarded		Improper warnings
	Poor working conditions		Poor housekeeping
	Other, please describe :		

An unsafe act resulted from, check all that apply			
	Lack of training		Not using safety devices
	Not following rules		Inattention
	Haste / chance taking		Horseplay
	Improper work method		Improper body position
	Other, please describe :		

Posture of employee, check all that apply			
	Sitting		Driving or riding vehicle or equipment
	Standing		Kneeling or standing
	Lying on ground or floor		Lifting or reaching
	Other, please describe :		

Supervision, check one that applies					
	Directly supervised		Indirectly supervised		Not supervised

EMPLOYEE WAS WORKING (mark one) ALONE _____ WITH CREW OR FELLOW WORKER _____

_____ _____
Supervisor's Signature Department Head's Signature (optional)

_____ _____
Occupational Health Nurse's Signature Date Received