**Employee’s Incident Report**

(to be completed by employee only)

Today’s Date: / / Time of this report: : am pm

Employee Name: Date of Birth: / /

(First) (Middle) (Last)

Social Security Number: - - Home Telephone: ( ) Other Telephone: ( )

Home Address: City: State: Zip:

Job Title:

Date of Incident: / / Time Started Work: : am pm Time of Incident: : am pm

Location of Incident:

(Physical Address) (Area of worksite)

In your words, describe fully how the incident happened, including what specific activity you were doing just before and when the incident took place, as well as the chain of events leading up to the incident:

*Include words such as pushing, pulling, climbing, etc. ….. note any objects, equipment, or tools involved……note special characteristics in the work*

*environment contributing to the incident.*

Was there property damage? Yes No If yes, what property/equipment was damaged?   
  
 Property/equipment owned by:

Describe the damage:

Describe what part of your body is injured/ hurt and in what way: OR  No injury  
*Examples: Sharp pain in right shoulder, bruised left knee, throbbing pain in left calf, etc……*

\*\*\*\*Please also indicate these areas of injury on the diagram on page 2\*\*\*\*

Can you think of anything you could have done differently or how possibly we can prevent this incident from happening again?

Were you working where other co-workers were nearby or present when the incident happened?  Yes  No

If so, who:

Name(s) of Witness(es) who may have seen/heard the incident: 1. 2.

(First) (Last) (First) (Last)

Who did you report this incident to?

(First) (Last)

Name of your supervisor:

(First) (Last)

When did you first report this incident to your supervisor? Date: / / Time: : am pm

**Do you require medical attention?**

**N/A, no injury**

**Yes**

We ask that you turn in any documentation received from the healthcare provider regarding your visit,   
 to include any medication prescribed, return to work status, and diagnosis so that the Personnel Office may ensure

timely processing.

**No** (if no is checked, please complete medical waiver below):

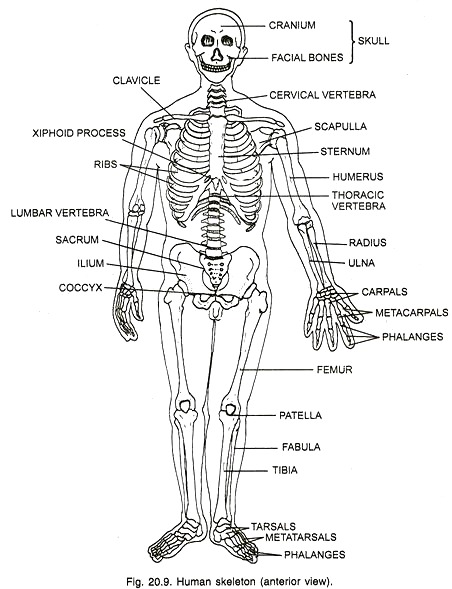
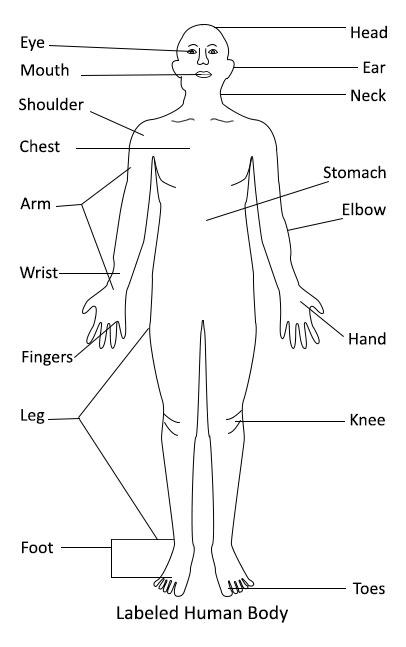
Medical Waiver:

The Lee County Commission is concerned with every employee’s well being. In the event you elect not to seek medical attention, this waiver is to document that your decision has not been influenced, in any way, by the Lee County Commission, which may include your immediate supervisor or other authorized authority.

My signature here confirms that I have voluntarily waived medical care due to the injury indicated on page 1, occurring on \_\_\_\_\_\_\_\_\_\_\_. Should it later be determined that I require medical care, I will consult with the Personnel Department **BEFORE** seeking treatment, unless emergency treatment is required. If the latter is the case, I will inform the Personnel Department as soon as practical.

Employee Signature:

**Directions:** On the body diagram below, please mark with a dot ( ) the area(s) of your body you feel has been injured as   
 a result of this incident.



I certify that these are true and accurate statements of my incident/injury that occurred on / / .

Signature of Employee :

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\*\*\***Please note:** You are required to report for a drug and alcohol test immediately after completing this form. You may have to

inform the healthcare provider or clinic of this requirement.

Received By (print name): Job Title:

(First) (Last)

Signature: Date: / / Time: : am pm   
  
   
 Forwarded to Personnel Department / / .

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