City of Richmond Employee Incident Report Form

EMPLOYEE TO COMPLETE THIS SECTION OF FORM

EMPLOYEE NAME:	GENDER: AGE:
JOB TITLE:	DEPARTMENT:
INCIDENT DATE: TIME:	LOCATION OF INCIDENT:
DATE REPORTED:	REPORTED TO:
NATURE OF INJURY:	WITNESSES:

INJURY SOURCE
(e.g., wet pavement, jack hammer, keyboard, etc.)

HOW INJURY OCCURRED
(struck by…, fell from…, exposed to…, etc.)

EMPLOYEE'S STATEMENT OF WHAT OCCURRED (Include as much detail as possible such as activity being performed, objects carried, equipment used, hazardous conditions, etc.)

Check one:

◯ I am not requesting any medical treatment at this time. I understand that I am not filing a workers' compensation claim at this time. I do not choose to complete the DWC 1 "Employee's Claim for Workers' Compensation Benefits" at this time. I understand I have one year to seek medical treatment, and if I do, I will immediately inform my supervisor and complete a DWC 1 claim form.

◯ I am seeking medical treatment from either a pre-designated physician or the city designated occupational medical provider and choose to complete the DWC 1 "Employee's Claim for Workers' Compensation Benefits." After each medical appointment, I will immediately provide my supervisor with the work status or restrictions provided by the physician.

The above information is true and correct to the best of my knowledge.

EMPLOYEE SIGNATURE: _____ DATE: _____

SUPERVISOR TO COMPLETE THIS SECTION OF FORM

HOW INJURY OCCURRED – Investigate how the injury occurred and determine whether it was caused by an unsafe act or unsafe condition, or both. Use the sections below to detail the nature of the act(s) or condition(s) that may have caused or contributed to the incident.

AN UNSAFE CONDITION EXISTED (Check all that apply):

☐ Defective equipment-tools ☐ Slippery or uneven walking surfaces ☐ Faulty layout of facilities
☐ Equipment not properly guarded ☐ Poor working conditions (light, ventilation) ☐ Poor housekeeping
☐ Other – specify: ☐ No unsafe condition existed

What have <u>you</u> done to eliminate these conditions? (e.g., eliminate condition, repair condition, report condition, etc.)

AN UNSAFE ACT RESULTED FROM (Check all that apply):

☐ Lack of training ☐ Not using personal safety devices ☐ Horseplay ☐ Boredom: inattention
☐ Not following rules ☐ Physical or mental handicap ☐ Improper work method ☐ Improper body position
☐ Haste / chance taking ☐ Other – specify: ☐ No unsafe act existed

What have <u>you</u> done to correct this act? (e.g., provide additional training, modify/discontinue work practice, etc.)

Did injured report to a physician? Yes ☐ No ☐ Did injured require hospitalization? Yes ☐ No ☐	Name and address of physician:
Did injured go home? Yes ☐ No ☐	Date injured left the job: Time:
DWC 1 Claim Form Provided Yes ☐ No ☐	Date or estimated date of return to work:

SUPERVISORY SIGNATURES

SUPERVISOR: (*Print)*	DATE
SUPERVISOR SIGNATURE:	DEPT HEAD SIGNATURE: