TOWN OF DAVIE
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Risk Management

Supervisor's On-The-Job Incident/Injury Report (Employee Injuries Only)

REPORT MUST BE COMPLETED WITHIN 7 DAYS OF THE INCIDENT/INJURY

EMPLOYEE INFORMATION

Name of Injured Employee:		**Date of Birth:**
Home Address:		**Telephone:**
Job Title/Position:	**Department:**	**Hire Date:**
Shift Hours:		

INCIDENT/INJURY

Date of incident/injury:	Time of incident/injury: ☐AM ☐PM	Date incident/injury was reported:	Did incident/injury occur during work hours: ☐YES ☐NO
Exact location of incident/injury:			
Last date worked:	Did the injury occur while operating a motor vehicle: ☐YES ☐NO If Yes, please provide responding agency and case#.	Agency and Case#:	
Description of the events preceding the incident/injury:			
What was the injured employee doing up to the time of incident/injury: (bending, standing, walking, etc.)			
What equipment or tools were involved when the incident/injury occurred:			
Was required safety equipment/PPE worn at time of the incident/injury: ☐YES ☐ NO ☐ N/A If YES or NO, please explain			
Did the condition around the employee, including the floor or machinery, play a part in the incident/injury: ☐YES ☐ NO If YES, please describe explanation below:			
Was any other employee a factor in this incident/injury: ☐YES ☐ NO If YES, please describe explanation below:			

What object(s) or substance(s) directly harmed the injured employee:

Witnesses:
☐YES ☐ NO

Witness Name 1:	Phone:	Witness Name 2:	Phone:
Witness Name 3:	Phone:	Witness Name 4:	Phone:

Did employee seek medical attention ☐YES ☐ NO If YES, please provide Name of Facility: Name of Facility:

Was employee treated in the emergency room: ☐YES ☐ NO If YES, please provide Name of Facility: Name of Facility:

Was employee hospitalized overnight as "in-patient" ☐YES ☐ NO If YES, when was he or she discharged: Discharged:

Is there video that captured the incident/injury: ☐YES ☐ NO If YES, please describe the camera location(s) Location(s):

Did the weather play a factor in causing the incident/injury:
☐YES ☐ NO If YES, please describe:

Did the employee commit any violation to Department or Town policy:
☐YES ☐ NO If YES, please describe:

(A) Part of Body Injured (If more than on, check all that apply)	**(B) Nature of Injury/Illness**	**(C) Activity Performed at Time of Accident**	**(D) Sources of Injury/Accident**
□ Abdomen □ Ankle(s) (L) (R) □ Arm(s) (L) (R) □ Back □ Breast(s) (L) (R) □ Buttock(s) (L) (R) □ Cheek(s) □ Chest □ Ear(s) (L) (R) □ Elbow(s) (L) (R) □ Eye(s) (L) (R) □ Finger(s) (LH)(RH) □ Foot/Feet (L) (R) □ Groin (L) (R) □ Hand(s) (L) (R) □ Head/Neck Area □ Heart □ Hip(s) (L) (R) □ Knee(s) (L) (R) □ Leg(s) (L) (R) □ Lip(s) □ Lung(s) (L) (R) □ Nose □ Shoulder(s) (L) (R) □ Stomach □ Toe/Toes □ Tooth/Teeth (Upper/Lower) □ Wrist(s) (L) (R) Other (specify): _____ _____ _____	□ Abrasion □ Allergic Reaction □ Amputation □ Bite □ Blunt Trauma □ Bruise □ Burn □ Chest Pain □ Choking/Suffocation □ Dizziness/Nausea □ Electric Shock □ Exposure □ Food Poisoning □ Foreign Body Eye/Ear □ Fracture □ Head Injury □ Hearing Loss □ Hernia □ Laceration/Cut □ Pain □ Puncture/Stab Wound □ Skin Condition □ Slip/Trip/Fall □ Smoke Inhalation □ Strain/Sprain □ Vision Loss □ Other (specify): _____ _____ _____	□ Bending □ Climbing □ Data Entry □ Driving □ Eating/Drinking □ Entering/Exiting Property □ Entering/Exiting Vehicle □ Jumping □ Kneeling □ Lifting □ Operating Equipment □ Pulling/Pushing □ Reaching □ Repetitive Motion □ Riding on Vehicle □ Running □ Sitting □ Standing □ Sweeping/Raking □ Twisting □ Walking □ Other (specify): _____ _____ _____	□ Animal/Insect □ Assault/Battery □ Blood/Body Fluid □ Broken/Faulty Equipment □ Chemical Agent □ Collapsed Structure □ Dust /Debris □ Electrical Equipment □ Environmental (heat, cold, noise) □ Falling Object □ Fire/Explosion □ Food/Beverage/Medicine □ Infectious Disease □ Medical Condition □ Office Equipment/Furniture/Machines □ Personal Contact □ Sharp/Blunt Instrument □ Slippery/Wet Surface □ Tools □ Unforeseen Hazards (uneven sidewalks, pavements, broken glass, etc). □ Vegetation □ Vehicular Accident □ Weapon □ Other (specify): List action(s) needed to prevent reoccurrence:_____ _____ _____ _____

COMMENTS AND RECOMMENDATIONS

Additional comments and recommendation for prevention of similar occurrences:

REQUIRED SIGNATURES

EMPLOYEE SIGNATURE SECTION

My Signature below indicates that the contents of this form have been discussed with me by my supervisor or another member of management. My signature does not constitute agreement with the contents. I understand that I am able to submit written comments addressing the contents of this form.

Employee Name:	Employee Signature:	Date:

SUPERVISOR/DIRECTOR SECTION

Supervisor Name:	Supervisor Signature	Date:
Supervisor Name:	Supervisor Signature	Date:
Department Dir. Name	Department Dir. Signature	Date:
Division Manager Name	Division Manager Signature	Date:

RISK MANAGEMENT SECTION

Comments:

Recommendations for prevention of similar occurrences:

Risk Manager Name:	Risk Manager Signature:	Date:

CC: Employee, Supervisor, Department Director, Risk Management