GENESEE COUNTY—EMPLOYEE ACCIDENT OR INCIDENT REPORT FORM

This side of the form is to be completed by the employee within 24 hours of the incident or injury and given to the supervisor for completion

DO NOT WRITE IN SHADED AREAS

I. EMPLOYEE DATA

FILL IN ALL SPACES-PRINT LEGIBLY - ALL INFORMATION MUST BE COMPLETED

DEPARTMENT	DEPT. CODE	EMPLOYEES WORK PHONE	SUPERVISORS NAME

EMPLOYEE'S NAME	OPTIONAL E-MAIL ADDRESS (HOME OR WORK)	JOB CLASSIFICATION

HOME ADDRESS	SOCIAL SECURITY #-REQUIRED	DATE OF BIRTH

CITY	STATE	ZIPCODE	EMPLOYMENT CATEGORY
			REG. FULL TIME REG. PART TIME TEMPORARY SEASONAL

GENDER	MARITAL STATUS	# OF DEPENDENTS	PHONE # -REQUIRED	LENGTH OF COUNTY EMPLOYMENT
M F	MARRIED SINGLE			LESS THAN 6 MONTHS 6 MOS TO 1 YR. 1 YR TO 5 YRS MORE THAN 5 YRS

TIME OF INJURY	DURING SHIFT _____	SHIFT SCHEDULE	TIME IN CURRENT POSITION AT TIME OF THE ACCIDENT
AM PM	DURING OVERTIME	START FINISH	LESS THAN 6 MONTHS 6MOS TO 1 YR. 1-5 YRS OVER 5 YRS

II. INJURY & LOCATION DATA

ADD ADDITIONAL PAGES IF NECESSARY

LOC #

DATE OF INCIDENT OR INJURY	LAST DATE WORKED	BUILDING OR ADDRESS WHERE INJURY OCCURRED	CITY

WHAT WAS EMPLOYEE DOING JUST BEFORE THE INJURY (DESCRIBE ACTIVITY, EQUIPMENT IN USE, MATERIALS OR TOOLS. BE SPECIFIC.)

_____

_____

_____

HOW DID INJURY OCCUR? (EXAMPLE--WALKING IN HALL, SLIPPED ON SPILLED COFFEE AND FELL. CUTTING TREE LIMB. SAW CUT LEFT THUMB.)

_____

_____

_____

DESCRIBE YOUR INJURY [STRAIN, SPRAIN, LACERATION, ETC.])

PART OF BODY AFFECTED (LEFT THUMB, FOREHEAD, LOW BACK, LIST ANY MULTIPLE)

WHAT OBJECT OR SUBSTANCE DIRECTLY HARMED YOU? (EXAMPLES: CONCRETE FLOOR, ELECTRIC SAW, GROUND, CHEMICAL-INCLUDE NAME OF CHEMICAL)

LIST ANY WITNESSES. INCLUDE THEIR PHONE NUMBERS:

1._____ 2._____

3._____ 4._____

WHAT ACTION OR PROCEDURE COULD YOU, THE EMPLOYEE HAVE DONE, TO AVOID THIS INJURY. BE THOUGHTFUL. THIS IS FOR LEARNING, NOT FOR FAULT FINDING.

_____

_____

III. MEDICAL TREATMENT

DURING THE FIRST TWENTY-EIGHT (28) DAYS OF MEDICAL CARE/TREATMENT, YOU **MUST** SEEK TREATMENT AT A COUNTY RISK MANAGEMENT APPROVED FACILITY. AFTER TWENTY-EIGHT (28) DAYS, YOU MAY SEEK TREATMENT WITH A DOCTOR OF YOUR CHOICE. **BEFORE** CHANGING PHYSICIANS, IT IS NECESSARY TO NOTIFY RISK MANAGEMENT, IN WRITING, OF THE PROPOSED CHANGE AND PROVIDE THE NEW TREATING PHYSICIANS NAME, ADDRESS AND TELEPHONE. THAT DOCTOR MUST COMPLY WITH THE REPORTING REQUIREMENT FOR WORKERS COMPENSATION INJURIES. CONTACT RISK MANAGEMENT FOR FURTHER ASSISTANCE.

ANY MEDICAL TREATMENT? YES NO	WERE YOU TAKEN BY AMBULANCE? YES NO	IF YOU HAD MEDICAL TREATMENT, SIGN AND SUBMIT THE MEDICAL RELEASE FORM WITH THIS REPORT

TREATMENT LOCATION:

_____HURLEY OCC. MED. CLINIC (1 Hurley Plaza, Flint, MI 48503)

____EMERGENCY ROOM-HOSPITAL: _____ (PUT NAME OF HOSPITAL IN SPACE)

_____OTHER_____

BY SIGNING THIS FORM, YOU ARE AFFIRMING THAT THE ABOVE INFORMATION IS ACCURATE AND TRUE. YOU ARE ALSO STATING THAT THIS ACCIDENT OCCURRED AT WORK. FRAUDULENT FILING OF WORKER COMPENSATION CLAIMS MAY BE SUBJECT TO COUNTY DISCIPLINARY ACTION UP TO AND INCLUDING IMMEDIATE DISMISSAL.

DATE: _____ EMPLOYEE SIGNATURE _____

DO NOT WRITE IN THIS BOX

DATE REC'D IN RM _____

IV. THIS SIDE OF FORM IS TO BE COMPLETED BY THE SUPERVISOR. AFTER COMPLETION, VERIFY INFORMATION AND COMPLETENESS OF EMPLOYEE SIDE AND SUBMIT THE FORM AND MEDICAL RELEASE FORM IF THE EMPLOYEE HAS HAD MEDICAL TREATMENT TO RISK MANAGEMENT AS SOON AS FEASIBLE. THERE IS A 24 HOUR TIME-FRAME FOR REPORTING INCIDENTS

FOR QUESTIONS ON THIS FORM, CONTACT THE RISK MANAGER AT 810-257-2628. FAX: 810-257-3502

THE ORIGINAL SHOULD BE SENT TO RISK MANAGEMENT EVEN IF FAXED.

EMPLOYEE NAME	DATE OF INCIDENT	DATE YOU WERE NOTIFIED	LAST DAY EMPLOYEE WORKED

IS THE TASK RELATED TO THIS INJURY WITHIN THE NORMAL JOB TASKS FOR THIS EMPLOYEE? HAD THE EMPLOYEE BEEN TRAINED? IF NOT, PLEASE ELABORATE.

_____

_____

WHAT SPECIFIC ACTIVITY WAS EMPLOYEE PERFORMING	WAS EMPLOYEE WORKING: ____ALONE ____WITH CREW OR OTHER EMPLOYEE ____OTHER	SUPERVISED ____ DIRECTLY ____ INDIRECTLY

V. ADDITIONAL INFORMATION AND CONTRIBUTING FACTORS. CIRCLE ALL THOSE THAT APPLY

CAUSATION CODE:

CONTACT WITH:
- ACID
- HOT OBJECT
- FLAME/FIRE
- STEAM/HOT FLUID

EXPOSURE TO:
- RADIATION
- DUST/FUMES/GAS
- ELECTRIC CURRENT
- COMMUNICABLE DISEASE (BLOOD BORNE PATHOGEN)

SLIPS TRIPS & FALLS:
- ON SAME LEVEL
- ON DIFFERENT LEVEL (STAIRS)
- DIFFERENT LEVEL (NON-STAIRS)
- LADDER SCAFFOLD
- ON WET/ICY SURFACE
- ON GREASY SERVICE
- SLIPPED, NO FALL
- TRIPPED

STRUCK BY OBJECT (OBJECT MOVING)

STRUCK AGAINST (STATIONARY) OBJECT

STRUCK BY FLYING OBJECT (FOREIGN OBJECT IN EYE)

CAUGHT BETWEEN MOVING OBJECTS (AS MACHINERY)

MOTOR VEHICLE ACCIDENT (AS PASSENGER OR DRIVER)

STRUCK BY MOTOR VEHICLE (PEDESTRIAN)

MATERIAL HANDLING: INDICATE AS COMPLETELY AS POSSIBLE
- HOLDING OBJECT
- CARRYING OBJECT
- LIFTING OBJECT
- PUSHING
- PULLING
- REACHING

HUMAN INTERACTION:
- ASSUALT/ATTTACKED BY
- RESTRAINING PERSON
- LIFTING PERSON

MISCELLANEOUS:
- INSECT/ANIMAL CONTACT
- CUMULATIVE TYPE INJURY (REPETITIVE MOTION)
- FATALITY (INDICATE OTHER CAUSE ABOVE)
- UNKNOWN

VI. CORRECTIVE ACTION NECESSARY TO PREVENT RECURRENCE OF THIS INCIDENT/ACCIDENT

IN ORDER TO EFFECTIVELY DECREASE THE POTENTIAL FOR RECURRENCE, A CORRECTIVE ACTION MUST BE IDENTIFIED AND COMPLETED. THIS IS AN ESSENTIAL PART OF LOSS MANAGEMENT. PLEASE DESCRIBE HOW THIS INJURY/INCIDENT COULD HAVE BEEN AVOIDED. CONSIDERATION SHOULD BE GIVEN TO 1.) ENFORCING WORK/SAFETY RULES, 2.) RETRAINING THE INDIVIDUAL ON THE CORRECT PROCEDURE OR PROCESS, 3.) REVISED PROCESSES 4.) CORRECTION OF DEFECT IN EQUIPMENT OR PREMISES

_____

_____

_____

IF A CORRECTION OF THE DEFECT IS NECESSARY, HAS IT BEEN REQUESTED OR ORDERED? _____ HAS IT BEEN COMPLETED?_____ IF SO, WHAT DATE? _____

EXPLAIN ANY ADDITIONAL ACTIONS, REVIEWS OR SUGGESTIONS THAT MAY CONTRIBUTE TO IMPROVED SAFETY WITHIN THE DEPARTMENT.

VII. PERSONAL PROTECTIVE EQUIPMENT REQUIRED FOR

LIST ALL PROTECTIVE EQUIPMENT THE EMPLOYEE IS REQUIRED TO WEAR FOR THIS JOB ASSIGNMENT:

_____

_____

_____

WHAT EQUIPMENT WAS THE EMPLOYEE WEARING AT THE TIME OF THE INCIDENT/ACCIDENT?

_____

_____

DATE OF LAST EQUPMENT TRAINING

VIII. SEVERITY OF THE INJURY

DESCRIBE THE SEVERITY OF THE INJURY:

☐ LOST TIME ☐ NO LOST TIME ☐ FIRST AID CASE

☐ WORK WITH RESTRICTIONS ☐ MEDICAL TREATMENT ONLY

☐ **FATALITY Contact MIOSHA if a fatality occurs and immediately notifies Risk Mgmt.**

Risk Manager (810)-257-2628 MIOSHA 1-(800)-858-0397

SUPERVISOR INFORMATION: PLEASE PRINT

_____
NAME

_____ _____
PHONE DATE EMPLOYEE GAVE INFORMATION

IX. REQUIRED SIGNATURES

IMMEDIATE SUPERVISOR_____ **DATE SIGNED** _____

DEPARTMENT/DIVISION HEAD _____ **DATE SIGNED** _____