CITY OF RIVIERA BEACH INCIDENT/INJURY REPORT

Employee and Supervisor must complete report within three (3) hours of injury/accident and submit to Department Head. Department Head or designee must submit to Risk Management Division within 24 hours.

EMPLOYEE INFORMATION: UNLESS IMPAIRED, THIS FORM MUST BE COMPLETED BY THE EMPLOYEE

CLAIMANT/EMPLOYEE NAME:_________________________________ **JOB TITLE:**______________________

ADDRESS:________________________________ **CITY/STATE:**___________________ **ZIP:**________________

DATE OF BIRTH:________________________ **DATE OF EMPLOYMENT:**___________________________

HOME/CELL PHONE NUMBER:________________________________ **SSN #:**_________________________

DATE OF ACCIDENT:______________________ **TIME:**__________ **LOCATION:**______________________

WERE POLICE NOTIFIED: (   ) YES (   ) NO **If yes - POLICE REPORT #:**____________________________

WITNESS: (if any)_____________________________ **WITNESS: (if any)**_____________________________

Name	Name
Address	Address
Phone No.	Phone No.

DATE AND TIME FIRST REPORTED:______________________________ **REPORTED TO:**___________________

DESCRIPTION OF INCIDENT AND JOB ENGAGED IN AT THE TIME OF INJURY (Be Specific; use extra sheet if necessary):____

____

NATURE AND EXTENT OF INJURIES – (Part of the body injured, i.e. upper left shoulder, middle finger on right hand bruised):____

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PLEASE PROVIDE PHOTOS OF THE INJURY, WHERE THE INJURY OCCURRED AND ANY ITEMS RELATED TO THE CAUSE OF THE INJURY.

(SUPERVISOR ONLY) **DESCRIBE ANY UNSAFE ACTS, CONDITIONS, OR PRACTICES AND RECOMMENDATIONS TO PREVENT REOCCURRENCE:**____

____

NAME OF FACILITY OR HOSPITAL SENT FOR TREATMENT:____

______________________________________ ______________________________
EMPLOYEE SIGNATURE **DATE**

______________________________________ ______________________________
SUPERVISOR SIGNATURE **DATE**

______________________________________ ______________________________
DEPARTMENT HEAD SIGNATURE (or designee) **DATE**