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)_____
Name

_____
Address

_____
Phone No.

WITNESS: (if any)_____
Name

_____
Address

_____
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):_____

_____

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**