CITY OF ARCADIA
EMPLOYEE INCIDENT/INJURY REPORT

OSHA Case No.
☐ Fatality Date _____
☐ Incident ☐ Injury

ALL INCIDENTS/INJURIES, EVEN MINOR ONES, MUST BE REPORTED. Complete this report on day of the incident/ injury or as soon as possible. All questions are important. Complete in detail. Failure to complete in a timely manner may deny/delay workers compensation benefits. If a work-connected fatality or serious injury occurs, please notify the Human Resources Administrator immediately. Every employer is required to report the incident immediately (within 8 hours) by telephone or in person to the nearest District Office of the Division of Occupational Safety and Health. Reference: General Industry Safety Orders Section 342 reporting Work-Connected Fatalities and Serious Injuries.

ATTENTION: This form contains information relating to employee health and must be used in a manner that protects the confidentiality of employees to the extent possible while the information is being used for occupational safety and health purposes. Reference: Section 14300-09 (b)(6)-(10).

PART I – To be completed by **EMPLOYEE** (please print) ☐ Volunteer

Name of Employee	☐ Male ☐ Female	Birth Date	Hire Date
Home Address (Street) (City) (Zip)		Phone No.	
Department	Job Title		
Date of Incident/Injury	Time of Event, If Known	Time Employee Began Shift	
Name of Witness (Address and phone #, if not an employee)			

Incident – Describe **HOW** & **WHERE** (Location). Describe what you were doing just before the incident/injury occurred. (If an injury occurred, please complete **Section A** below):

_____

_____

_____

_____

Part of Body Affected	**Section A:** Nature of Injury (e.g. Strain, Sprain, Fracture)
Employee Signature	Date

PART II – To be completed by the employee's **SUPERVISOR** whose evaluation is vital to future incident accident prevention activities pursuant to the City's Injury and Illness Prevention Program. Carefully evaluate the "act" or "condition" which caused the incident/injury.

An unsafe condition existed (check all that apply)

☐ Defective equipment – tools ☐ Slippery or uneven walking surfaces ☐ Poor working conditions (light, ventilation)
☐ Equipment not properly guarded ☐ Faulty layout of facilities ☐ Poor housekeeping
☐ Performing safety sensitive duties, such as arresting suspect/fire suppression. Please explain _____

An unsafe act resulted from (check all that apply)

☐ Not following safety rules ☐ Physical or mental handicap ☐ Improper work method ☐ Not using personal safety devices
☐ Improper body position ☐ Lack of Training ☐ Haste; chance taking ☐ Boredom; inattention
☐ Horseplay ☐ If other or could not be prevented, please explain _____

As a supervisor, what have you done to correct this action/ condition? (including employee training, counseling, and/or correcting equipment)

_____

_____

☐ I know this incident/injury occurred on duty ☐ I have no specific knowledge this injury occurred on duty

If the employee was injured, did employee go home? ☐ Yes ☐ No	Time employee went home: _____ ☐ a.m. ☐ p.m.	Did employee report to a physician: ☐ Yes ☐ No
Name and Address of physician:		
Was the employee treated in an emergency room (if yes, name of facility):		Did injury require hospitalization (if yes, name of facility):
Date or estimated date of return to work:		Was the employee acting in his/ her regular line of duty? ☐ Yes ☐ No
Name of supervisor completing this form:	Title	Phone Number:
Supervisor Signature	Date of Report	**IF AN INJURY OCCURS, NOTIFY HUMAN RESOURCES IMMEDIATELY and submit the following forms within 24 hours:** Admin Sure Report, Notification of Worker's Comp. Benefits, and if the employee submits, Workers' Compensation Claim Form.
Department Head's Signature	Risk Management Review	