

STARKE COUNTY
EMPLOYEE'S FIRST REPORT OF ACCIDENT

DATE & TIME OF REPORT:

PART 1: TO BE COMPLETED BY THE EMPLOYEE:

NAME:

HOME ADDRESS:

HOME PHONE NUMBER:

OCCUPATION AT THE TIME OF THE ACCIDENT (STATE POSITION/TITLE):

DEPARTMENT:

IMMEDIATE SUPERVISOR:

TIME AND PLACE OF ACCIDENT:

DATE AND TIME OF ACCIDENT:

LOCATION OF ACCIDENT:

DATE ACCIDENT REPORTED:

SUPERVISOR OR AUTHORITY TO WHOM REPORTED:

DESCRIPTION OF ACCIDENT:

FULLY DESCRIBE THE AREA AND CONDITIONS WHERE THE INCIDENT OCCURRED:

DESCRIBE IN DETAIL HOW THE ACCIDENT HAPPENED:

DESCRIBE THE NATURE OF ANY INJURY OR ILLNESS, INCLUDING SPECIFIC PARTS OF BODY AFFECTED:

WAS ON-SITE MINOR FIRST AID ADMINISTERED? YES NO

WERE THE POLICE NOTIFIED? YES NO

IF YES, WHICH DEPARTMENT/OFFICER?

DOES THE EMPLOYEE NEED TO SEEK MEDICAL TREATMENT? YES NO

COMMENTS:

I certify the above information is true and complete.

EMPLOYEE'S SIGNATURE: _____

DATE: _____

PART II: TO BE COMPLETED BY EMPLOYEE'S SUPERVISOR.

DATE AND TIME YOU WERE FIRST NOTIFIED OF THE ACCIDENT:

WAS THE INJURY/ILLNESS JOB RELATED? YES NO

WAS THE EMPLOYEE ON DUTY AT THE TIME OF THE ACCIDENT: YES NO

SUPERVISOR'S SIGNATURE AND TITLE: _____

DATE: _____