THE CITY OF WATERTOWN
Opportunity runs through it.

EMPLOYEE WORK RELATED INCIDENT INVESTIGATION REPORT

In all cases, Emergency Medical Care takes priority. All injuries/illnesses regardless of severity must be reported to the Supervisor immediately. This form and applicable paperwork must be completed and submitted to your Supervisor within 24 hours of the incident occurring.

Prior to all non-emergency medical appointments for this injury, you must obtain a form from the Human Resource office to be completed by your doctor.

Name: _____ Date of Hire: _____

Job Title: _____ Date of Birth: _____

Home Department: _____ Phone Number: _____

Work Schedule on day injury: _____ Email: _____

Date & Time Reported: _____ AM or PM Preferred Contact Method: _____

Number of weekly scheduled hours: _____ Reported to Whom: _____

Date of Incident: _____ Time of incident/accident: _____ AM or PM

Location of Incident: _____ Did you work the full day: Yes/No

Witnesses: _____ Time left if no: _____

Describe activity prior to the accident: _____

_____

_____

What happened that resulted in the injury (Please be specific): _____

_____

_____

_____

How could the accident have been prevented? _____

_____

_____

Please circle and check the appropriate box where your injury occurred on the diagram below:

❑	**Head**	❑	**Shoulder**
❑	**Arm**	❑	**Chest**
❑	**Back**	❑	**Abdomen**
❑	**Wrist**	❑	**Hand**
❑	**Groin**	❑	**Hip**
❑	**Leg**	❑	**Butt**
❑	**Ankle**	❑	**Knee**
❑	**Foot**	❑	**Thumb**
❑	**Finger**		

❑ **Left** ❑ **Right**

❑ **Front** ❑ **Back**

Please list any other comments you have regarding your injury:_____

_____

_____

Have you ever injured this part of your body before?_____

If so, when?_____

Was First Aide Sought? ❑ Yes ❑ No

Describe First Aide received:_____

Who Administered First Aide:_____

Employee's Signature:_____Date:_____

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It is our policy to provide prompt and appropriate medical treatment to employees for work-related injuries. There are situations that arise where notice of an injury may be made, and formal treatment is not necessary.

When an employee reports a work-related injury, the injury will be documented, and treatment will be offered. An employee may indicate a preference not to have formal medical treatment. In the event that an employee declines medical treatment, we will have the employee sign below indicating that they declined medical treatment.

❑ **I am declining medical treatment at this time. Should my condition worsen, or should I change my mind regarding treatment, I know I must inform my supervisor immediately.**

Injured Employee's Signature: _____ Date:_____

Supervisor's Signature: _____ Date:_____

❑ **My injury/injuries have completely resolved.** Date:

Injured Employee's Signature: _____ Date:_____

Supervisor's Signature: _____ Date:_____

Did you seek medical Care? ❑ Yes ❑ No

If medical care was sought, where did you seek care? _____

*Please submit a copy of your medical documentation to Human Resources

CITY OF WATERTOWN
SUPERVISOR'S REPORT ON INCIDENT/INJURY
TO BE COMPLETED BY SUPERVISOR OF INJURED EMPLOYEE

Name of Injured Employee:		Date Employee Informed You of Injury:
Supervisor Name:	Supervisor Title:	Supervisor Daytime Phone:
Describe the injury/incident:		
Describe the cause of injury/incident:		
What action will be taken to prevent recurrence of this type of injury/incident?		
Will the injury or incident result in lost work time?_____Yes_____No		
What safety equipment, if any, was in use at the time of the injury/incident?		
List any additional comments or concerns regarding this injury/incident:		

Supervisor Signature:_____ Date:_____

Department Head Signature: _____ Date:_____

If Supervisor is not Department Head

CITY OF WATERTOWN
WITNESS REPORT ON INCIDENT/INJURY
TO BE COMPLETED BY ALL WITNESSES

Name of Injured Employee:		Date of Injury:
Witness Name:	Witness Title:	Witness Daytime Phone:
Describe the injury/incident:		
Describe the cause of this injury/incident:		
Do you have a recommendation on how to prevent recurrence of this type of injury/incident?		
What safety equipment, if any, was in use at the time of the injury/incident?		
List any additional comments or concerns regarding this injury/incident:		

Witness Signature:_____ **Date:**_____

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CITY OF WATERTOWN
WITNESS REPORT ON INCIDENT/INJURY
TO BE COMPLETED BY ALL WITNESSES

Name of Injured Employee:		Date of Injury:
Witness Name:	Witness Title:	Witness Daytime Phone:
Describe the injury/incident:		
Describe the cause of this injury/incident:		
Do you have a recommendation on how to prevent recurrence of this type of injury/incident?		
What safety equipment, if any, was in use at the time of the injury/incident?		
List any additional comments or concerns regarding this injury/incident:		

Witness Signature: _____ Date:_____

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