Injury / Illness Report

Accident Information **Claim No:**

Date of accident: Department:

Brief Description of the accident:

Additional Information:

Medical Care Administered (*Check One*): None ☐ Clinic-Hospital ☐ Doctor ☐
Photos taken (*Check One*): Yes ☐ No ☐
Was the area Dry (*Check One*): Yes ☐ No ☐
Was the area clean? (Check *One*): Yes ☐ No ☐
How was the lighting? (*Check two*): Daytime ☐ Nighttime ☐ Indoor ☐ Outdoor ☐ Stormy Conditions ☐

Address or Place of accident:

Specific Location of accident:
(roadway, hallway, sidewalk, etc.)

Name & Phone # of Individual Completing the Form:

Basic Information – All Injured Parties

(*Check One*): Employee ☐ Volunteer ☐ Poll Worker ☐ Citizen ☐ Temporary Employee ☐

First Name: Street Address:
City:
Middle Name: State: Zip Code:

Last Name:

Home Phone # Alternate Phone #

Gender (*Check One*): Male ☐ Female ☐ Date of Birth: Social Security #:

Injured Body Part(s) (*if applicable*)
1.
2.
3.
4.
5.

Hospital/Clinic Information (if medical care administered)

Facility Name:

Doctor Name:

Employee Information Only

Employee #: Regular # of days worked weekly:

Hourly rate of pay: Regular # of hours worked daily:

Employee Work Schedule (check *the schedule routinely worked by the employee*)

Sunday:	Not Working ☐	First Shift ☐	Second Shift ☐	Third Shift ☐	Rotating Shift-Sheriff Only ☐
Monday:	Not Working ☐	First Shift ☐	Second Shift ☐	Third Shift ☐	Rotating Shift-Sheriff Only ☐
Tuesday:	Not Working ☐	First Shift ☐	Second Shift ☐	Third Shift ☐	Rotating Shift-Sheriff Only ☐
Wednesday:	Not Working ☐	First Shift ☐	Second Shift ☐	Third Shift ☐	Rotating Shift-Sheriff Only ☐
Thursday:	Not Working ☐	First Shift ☐	Second Shift ☐	Third Shift ☐	Rotating Shift-Sheriff Only ☐
Friday:	Not Working ☐	First Shift ☐	Second Shift ☐	Third Shift ☐	Rotating Shift-Sheriff Only ☐
Saturday:	Not Working ☐	First Shift ☐	Second Shift ☐	Third Shift ☐	Rotating Shift-Sheriff Only ☐

Witness Information:

Name: Address: Telephone #:

Alt Telephone #: