INJURY REPORT

Date:________________      Time:_______________    Incident #:______________________

Name:_______________________    Rank:  _________     Shift:____  Station:____________

Workers Compensation contacted?  Yes___   No___

Incident location:____________________________________  Grid:_____________________

Describe fully how incident occurred: _____________________________________________
____________________________________________________________________________
____________________________________________________________________________

Witnesses:
____________________________________________________________________________
____________________________________________________________________________

Was medical treatment given at the scene?  Yes___   No___
By whom:__________________________________

Was patient transported to hospital?   Yes___   No___
How:______________________________________

Was proper safety equipment used at time of injury?  Yes___   No___

Immediate Supervisor's safety analysis: ___________________________________________
___________________________________________________________________________
___________________________________________________________________________
___________________________________________________________________________

* (use back or additional sheets if necessary)*

Action taken to prevent future similar incidents: __________________________________
___________________________________________________________________________
___________________________________________________________________________
___________________________________________________________________________

Personnel status:   Continued duty____   Off Duty____
Medical disposition:____________________________________________________

Chief Officer's remarks: _______________________________________________________
___________________________________________________________________________
___________________________________________________________________________

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For Safety Committee   Review by Safety Committee   Date:__________

(check one)  Preventable____   Non-preventable____