HURON COUNTY INCIDENT REPORT (attach add'tl sheets as needed)

(To be used for all accidents or incidents involving employees, citizens, or patrons.)

Please PRINT or TYPE

Person/Equipment Involved: (check all that apply)

☐ Employee ☐ Citizen ☐ County Equipment

☐ County Vehicle ☐ Personal Vehicle ☐ Private Equipment

☐ County Real Estate ☐ Private Real Estate

Type of incident: (check all that apply)

☐ Injury – Complete Section A

☐ Automobile Accident – Complete Sections A and B

☐ Threat – Complete Sections A and C

Section A: (To be completed by employee unless physically unable.)

Date of Incident: ______________________ Time of Incident: ________________ AM/PM

Location of Incident: ____

Name of Employee involved/observing: ____

Date of Birth: ____________________ Date of Hire: ____________________

Name of Supervisor and Department: ____

Witnesses: _____________________________________ ____

Name Best contact Information

Witnesses: _____________________________________ ____

Name Best contact Information

Was a police report made? Yes ☐ No ☐ Report #____________________________

Which Police Department: ____

Describe the Incident and how it occurred:

____

____

____

____

What was the employee doing just before the incident occurred? Describe the activity, as well as the tool/material the employee was using. Be specific. (Examples: climbing a ladder while carrying roofing materials; daily computer key-entry)

____

____

____

Describe injuries or illness, if any, including parts of the body (e.g., right elbow, left upper thigh, death):

____

____

Describe treatment (e.g., Industrial Health Clinic, Emergency Room, EMS, First Aid, hospitalization, include facility where treatment was given)

____

____

What object or substance directly armed the employee? (Examples, concrete floor; chlorine, saw) If this question does not apply to the incident, leave it blank.

____

____

Section B: VEHICLE ACCIDENT – ADDITIONAL INFORMATION NEEDED

Law Enforcement Must be Notified!

Vehicle you were driving was: A county vehicle ☐ My private vehicle ☐

Employee driver information:

Driver's name, phone #, driver's license #: ____

____

Was the vehicle you were driving damaged:

Yes ☐ Vehicle license #, year, make, model:

____

____

No ☐

Did the accident involve another vehicle?

Yes ☐ Non-employee driver's license name, address, phone #, driver's license #:

____

____

No ☐

Injuries:

☐Employee driver ☐Non-employee driver ☐Other____________________

☐Employee passenger ☐Non-employee passenger

Were seatbelt(s) worn by the driver and all passengers in your vehicle? Yes ☐ No ☐

Names of Injured Party(ies):	Names of Witness(es):
______________________________ Injured Party #1	______________________________ Witness #1
______________________________ Address & Phone	______________________________ Address & Phone
______________________________ Injured Party #2	______________________________ Witness #2
______________________________ Address & Phone	______________________________ Address & Phone

Report was made with which Police Department:____
Report # _________________________________

Section C – THREAT – ADDITIONAL INFORMATION NEEDED
Law Enforcement Must be Notified!

Name of the person making the threat ____

Type of Threat (Choose all that apply)

- ☐ Verbal Aggression (w/sense of danger)
- ☐ Verbal/Written Threats of Harm
- ☐ Sexual Harassment
- ☐ Stalked by Client
- ☐ Physical Assault – not injured
- ☐ Physical Assault – injured *(please provide brief explanation)*
- ☐ Use of Weapon *(please provide type of weapon)*
- ☐ Other *(please provide brief explanation)*

ANY ACCIDENT OR INCIDENT OCCURRING DURING WORKING HOURS MUST BE REPORTED TO MANAGEMENT IMMEDIATELY. SUPERVISORS RECEIVING A REPORT MUST, IN TURN, NOTIFY THE HUMAN RESOURCES ADMINISTRATOR AND/OR EXECUTIVE DIRECTOR. THIS REPORT MUST BE FORWARDED TO THE HUMAN RESOURCES ADMINISTRATOR WITHIN 24 HOURS OF THE INCIDENT.

The information I have provided either in my own writing or verbally for the purpose of this form is true and correct. I understand that providing false or misleading information or omission of information on this report or any other form relating to this claim if involving injury or illness may result in disciplinary action, up to and including termination of my employment. Failure to complete this form or other forms relating to this claim and submit it in a timely fashion may result in non-certification of a Workers' Compensation claim.

Signature of Employee: _______________________________________ Date: _________________

Printed Name of Employee: ___________________________________

(To be completed by Supervisor)

Date & Time Informed of the Incident: _______________ By Whom: __________________________________
Did you investigate this incident? Yes ☐ No: ☐

Signature of Supervisor: _______________________________________ Date: _________________

Printed Name of Supervisor: ___________________________________

For HR Use Only

☐ Sent to County Safety Risk Officer ☐ Notified Executive Director

Yes ☐ N/A ☐ Discussed a safety plan with the employee and supervisor Date:____________________