SUPERVISOR

Incident/Accident Report

Please use this form to document any incident or accident involving a city employee or that occurs on city property. Regardless of the severity of the damage or injury, this form must be filled out completely for all incidents/accidents occurring during work or on city premises. Incident/Accident Reports must be completed within 3 days of occurrence.

To Be Completed by Employee's Supervisor. This form will be used by the city to improve safety practices and policies, so your attention in providing as much detail as possible is appreciated.

Injured Employee:	**Job Title:**
Department:	**Date of Incident/Accident:**

Please describe the injury or illness fully. *Describe your understanding of how, when and where the incident/accident occurred*:

In your opinion, what was the cause of this accident/incident?

☐ Broken or outdated tools/equipment	☐ Supervision	☐ Maintenance	☐ Weather conditions
☐ Lack of training	☐ Failure to follow work rules/procedures	☐ Inattention	☐ Horseplay
☐ Defective PPE		☐ Other:	

Explain:

Did employee report the accident/incident to you within 24 hours?	**Did you talk with the employee about safe work practices and accident prevention?**

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SUPERVISOR FINDINGS:

Please provide your review of what happened. What could have been done, or should be done to prevent this accident/incident?

Did employee miss any time from work? Yes / No / Explain at right ->	**Please explain what scheduled work days were missed:**
Was this accident preventable? Yes / No / List Recommendations at right ->	**What changes will you make to ensure this kind of incident/accident doesn't reoccur?** ***(List recommendations here)***

Has employee provided you with a release or return to work notice from his/her doctor?

Are you able to provide modified duty assignment within employee's restrictions?
If yes, please complete a "Modified Duty Acceptance Letter."

Please send medical notices to Human Resources for confidential storage.

Supervisor Signature: _____ **Date: _____**

Please make sure the injured employee tells his/her doctor that the injury occurred at work. Charges should be billed to:

TRISTAR RISK MANAGEMENT PO Box 23189 Tigard, OR 97281-3189	**For questions regarding claim status:** Julie Bartel, Senior Claims Examiner Julie.bartel@tristargroup.net Phone: 503-245-7592 * Fax: 503-245-7599

IMPORTANT: OR-OSHA requires that employers inform OSHA of all fatalities or catastrophes within 8 hours. To report a a death or catastrophic emergency that occurred at work requiring overnight hospitalization, call OSHA immediately at 1-800-922-2689.

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