ACCIDENT REPORT

CITY OF WAUPACA

NOTE TO EMPLOYEES AND SUPERVISORS: This Accident Report form is to be used in the event of any job related accident which occurs while in the active employment of the City of Waupaca, and is to be completed regardless of whether the accident results in personal injury to the employee or other person, or results in property damage. Part A of the report is to be completed by the employee or employees who were directly involved in the accident, and is to be completed as soon as practicable after the accident occurs. Part B of the report is to be completed by the supervisor or department manager, and is similarly to be completed as soon as practicable after the accident with consideration for a full and complete investigation of the facts. Where any job related incident or accident results in any injury or illness to an employee, supervisors and department managers are also required to complete the Employer's Report of Injury or Disease for the Workmen's compensation Division, and employees are required to cooperate by providing information when requested.

PART A
(For Employee)

Date of Report _____

1. Name of Employee or Employees Involved _____

_____

2. Department _____ 3. Classification _____

4. Date and Time of Accident _____ _____A.M. _____P.M.

5. Place of the Accident (Describe Precisely) _____

_____

_____

6. In what work were you engaged when the accident occurred? _____

_____

7. Description of the Accident (Describe as precisely as possible) _____

_____

_____

8. To what conditions or acts, do you attribute the Accident? _____

_____

_____

9. Was any person injured as a result of the Accident ( ) Yes ( ) No If yes, please complete the following:

(a) Name of Persons Injured _____
State exactly the
Part of the body injured _____
Name of the object or substance
which directly injured the person _____

(b) Was person injured ( ) Employee ( ) Other Persons

If non-employees, please give address if known _____

_____

(c) Was any person attended by a Physician or hospitalized as a result of the accident ( ) Yes ( ) No If yes, please give the name of the person and the Physician and/or Hospital _____

_____

_____

10. Did the accident result in property damage? ( ) Yes ( ) No If yes, please complete the following:

(a) Was the damage to ( ) City Property ( ) Other Property
If other property, please give owner and address if known _____

_____

_____

(b) Type of property damaged _____

_____

(c) Description of the damage _____

_____

(d) Estimated dollar value of damage $_____

11. What action could have been taken to prevent the accident or to prevent similar accidents? _____

_____

_____

12. Use this space for any additional comments _____

_____

_____
Signature of Employee

PART B
(For Supervisors)

Date of Report _____

1. Department Manager or Supervisor _____

2. Name of person investigating accident _____

3. Does the investigation of the accident reveal that the following facts conform to the contents of the employee's report in Part A.?

Yes	No	FACT
( )	( )	Name of Employee or Employees
( )	( )	Date and Time of Accident
( )	( )	Place of Accident
( )	( )	The nature of work involved
( )	( )	Description of the accident
( )	( )	The Conditions or Acts
( )	( )	Persons Injured
( )	( )	Attendance by Physician or Hospitalization
( )	( )	Property Damage
( )	( )	Estimated dollar value of damage

To the extent the results of the investigation does not conform to the employee's report,

Please use this space for details _____

_____

_____

_____

4. To what act or conditions do you attribute the accident? _____

_____

_____

_____

5. What action could have been taken to prevent the accident or to prevent similar accidents? _____

_____

6. Was any employee given a warning or discipline as a result of the accident?

( ) Yes ( ) No If yes, please describe and attach warning or discipline report

_____

_____

7. Recommendation for additional action _____

_____

_____

_____

_____

8. Use this space for any additional comments: _____

_____

_____

_____

_____

_____

_____

Supervisor/Department Manager

Did employee return to work? _____

Last Day Worked: _____

If not, days absent from work: _____

Date returned to work: _____

Name of Witnesses: _____