WAYNE COUNTY EMPLOYEE REPORT of ACCIDENT/INJURY

The employee must complete this report as soon as possible following an accident/injury. This report will provided to the supervisor within 24 hours of the accident/injury.

Name: **Date of Injury:** **Time of Injury** **AM PM**

SocialSecurity#: **Date of Birth:**

☐**Full Time** ☐**Part Time** **Date Employed:** **Dept #**

Home Address:

Start Time of Work **Day:** **AM PM**

Witnesses (attach statement for each)

Name: **Title:** **Phone Number:**

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Exact Location Injury Occurred / Duties Being Performed:

Describe the circumstances causing the injury:

Personal Protection Equipment Used:

☐**Foot Protection** ☐**Face/Eye Protection** ☐**Fall Protection** ☐**Respiratory Protection** ☐**Hand Protection**

☐**Head Protection** ☐**Apron/Chaps** ☐**Back Belt** ☐**Lifting Assistance Device** ☐**None**

☐**Other:** **Object, equipment, or substance, which caused injury:**

Lost Time/Restrictions:
Lost Time? ☐**No** ☐**Yes - From** **To:**

Restrictions? ☐**No** ☐**Yes - From** **To:**

Total Days of LOST Time or Restriction:

Corrective Action: **Recommendations to Prevent Reoccurrence:**

Date Completed: **By:**

Action Taken

Medical Treatment: ☐**No Treatment** ☐**First Aid** ☐**Outside Medical Treatment**

Employee's Signature:_____ **Title:**_____ **Date:**_____

Supervisor's Signature: :_____ **Title:**_____ **Date:**_____