



ADMINISTRATIVE SERVICES HUMAN RESOURCES
INJURY/ILLNESS INCIDENT REPORT

- #1 Report the incident to your Supervisor immediately.
#2 If you are injured, call HUMAN RESOURCES at 778-5300 for a Workers' Compensation Claims Packet.

EMPLOYEE VOLUNTEER WORK CREW

Name Department

Job Title Supervisor

Incident Date Location

Time Began Work AM / PM Time of Incident AM / PM

Medical Treatment No Yes If yes, Health Care Provider

Witness(es)

What happened? (Describe how the incident occurred, including what, where, when, why, how.)

What was the injury/illness and part of body affected?

Damage to equipment Damage to property Damage to vehicle

Please describe damage:

If County vehicle involved, follow directions on the Vehicle Accident Check List in vehicle glovebox.

Sheriff Called Pictures Taken Citation Issued

Signature Date

Supervisor Name Supervisor Title

What steps will you be taking to investigate and follow-up on this event?

Signature (following review by Department Head) Date

INJURED PARTY

DEPARTMENT