



NOTICE OF INJURY REPORT

This report must be completed and sent to the Safety Director within 24 hours of notification of incident. (Fax: 455-2782, Phone: 455-2648)

EMPLOYEE INFORMATION

(Please Print)

Name: _____ Sex: M F Department: _____

Date of Birth: ___/___/___ Hire Date: ___/___/___ Home Telephone #: (____)_____

Mailing Address or Street Address: _____

City, State, Zip: _____

NOTICE TO ALL EMPLOYEES - The City of Tullahoma is committed to providing a safe work place for all employees.

The purpose of this report is to:

- * Determine why this accident happened and how to keep it from happening again;
- * Provide information for insurance investigation and reports required by the State.

If you are injured at work:

- Tell your Supervisor immediately and complete the Injury Report within 24 hours when possible.
- If you need medical care other than first-aid, you will be referred to a physician or the hospital.
- Your accident will be investigated by your Supervisor and the Safety Director.
- Bring your doctors' notes and work releases to your supervisor immediately.
- If you are placed off work by your doctor, contact your supervisor each day.

FALSE CLAIMS - Any employee who knowingly attempts to obtain benefits to which they are not entitled is subject to disciplinary action up to and including termination of employment.

EMPLOYEE'S ACCIDENT REPORT

JOB INFORMATION

(Please Print)

Job Title: _____ Time you started work today: _____ am/pm (circle)

How long have you been doing this job? _____ Is this your normal job? Yes No

What personal protective equipment are you required to wear in your job? (Check **ALL** that apply)

hard hat earplugs safety glasses turnout gear dust mask/respirator
 gloves face shield safety vests steel-toed shoes Other - Describe _____

Were you using the required personal protective equipment? Yes No None required

Have you ever had this injury/illness before? Yes No If yes, date: _____

Describe prior incident: _____

EMPLOYEE'S ACCIDENT REPORT

INCIDENT DATA

(Please Print)

Date of incident: ____/____/____ Date requested medical attention: ____/____/____

Time of Incident: _____ am/pm (circle) Where did it happen? _____

What equipment or chemicals were you using when this happened? _____

What work process were you performing? (i.e., garbage collection, brush removal, law enforcement, fire fighting, grounds maintenance, etc.) _____

What were you doing specifically when the injury/illness occurred? (i.e., lifting, walking, running, driving, etc.) _____

Describe in detail the sequence of events and include objects, equipment or people that directly caused your injury:

Did you report this injury/illness to your Supervisor? ? Yes No If yes, date: _____

If no, why not? _____

Give name(s) of witness(es) to your injury/illness: _____

Do you have any recommendations for changes to prevent this injury / illness from occurring again ?

What part(s) of your body were hurt?

(Mark the appropriate blank or write in **R** for Right, **L** for Left when applicable.)

Head: ___Face ___Skull ___Neck ___Mouth ___Nose ___Eye ___Ear

Trunk: ___Chest ___Shoulder ___Upper back ___Lower back ___Abdomen ___Hip

Arm: ___Upper ___Elbow ___Wrist ___Hand ___Palm ___Finger

Leg: ___Foot ___Knee ___Thigh ___Ankle ___Calf ___Toe

Other: _____

What type of injury/illness do you have? (Check all that apply)

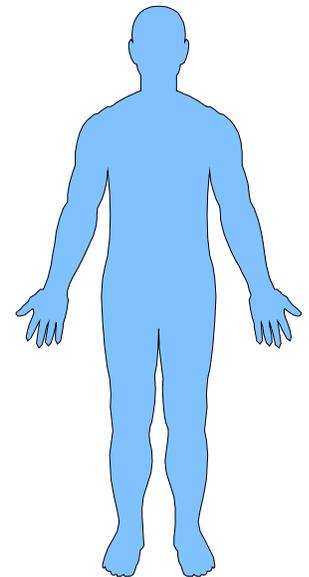
Abrasion (scrape) Strain/Sprain Bruise Poisoning (Ivy, Oak, Other)

Fracture Cut/Puncture Crush Burn

Respiratory Amputation Swelling Dislocation

Other: _____

Please circle the injured or affected area on the right.



All the information I have provided in this report is true and correct. I understand that providing false or misleading information or omission of information on this report or any other form related to this injury may result in termination of my employment.

Employee Signature: _____ Date: _____ Witness: _____

