

# Delaware County Incident Report



DELAWARE  
COUNTY *Ohio*

## INSTRUCTIONS:

- I. Employee and supervisor must complete this form and send to Human Resources within 24 hours of the incident.
- II. Supervisor must complete form in event employee does not or cannot complete form on their own.
- III. Supervisor must as soon as possible & within 24 hours submit email summary to: [incidentreport@co.delaware.oh.us](mailto:incidentreport@co.delaware.oh.us)
- IV. If anyone has questions please call Human Resources at 740-833-2127.

### EMPLOYEE INFORMATION:

Full Name: \_\_\_\_\_ Department: \_\_\_\_\_  
Address: \_\_\_\_\_ Job Title: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Date hired: \_\_\_\_\_  
Date of Birth: \_\_\_\_\_  Male  Female Work phone #: \_\_\_\_\_  
Personal phone #: \_\_\_\_\_ Time shift began: \_\_\_\_\_  
Signature: \_\_\_\_\_ Personal email: \_\_\_\_\_  
Date signed: \_\_\_\_\_

### INCIDENT INFORMATION (please use separate sheet if necessary):

Type of incident: (check all that apply)  Injury  Illness  Property Damage  Other

Date of incident: \_\_\_\_\_ Time of incident: \_\_\_\_\_

Did incident occur on regular shift:  Yes  No

Incident location: \_\_\_\_\_

What were you doing just before incident occurred? (Describe activity as well as tools used) Be specific:

What happened? Incident Description: (Tell how the incident occurred. Ex: Slipped on floor injured wrist, developed soreness over time.) \_\_\_\_\_

What injury or illness resulted from incident? (Describe body part and how it was affected by incident.) Be specific:

What object or substance harmed you from the incident? (Ex: concrete floor, radial arm saw.) \_\_\_\_\_

Was this activity part of your normal job duty?  Yes  No

### HEALTH CARE OR PHYSICIAN INFORMATION:

Name of physician or first aid provider: \_\_\_\_\_

If treatment was provided away from work site, where was it provided?

Facility: \_\_\_\_\_

Street: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Were you treated in Emergency Room?  Yes  No Were you hospitalized overnight?  Yes  No

Did the employee receive treatment classified as first aid at the worksite or hospital?  Yes  No

Did you miss any time from work after the day of the injury for this incident?  Yes  No

Did this incident cause an aggravation of a prior condition?  Yes  No If yes, describe prior condition:

**PROPERTY DAMAGE:** Was a law enforcement report taken?  Yes  No

By whom?  Sheriff  Police  State Highway Patrol  Other \_\_\_\_\_

Report # \_\_\_\_\_ (For property damage please send a copy of the law enforcement report as soon as possible)

**VEHICLE INFORMATION:**

Was a:  COUNTY or  PERSONAL vehicle involved?

**County Vehicle:**

Make \_\_\_\_\_ Vehicle Model \_\_\_\_\_ Vehicle Year \_\_\_\_\_ License Number \_\_\_\_\_

**Personal Vehicle:**

Make \_\_\_\_\_ Vehicle Model \_\_\_\_\_ Vehicle Year \_\_\_\_\_ License Number \_\_\_\_\_

**Other Vehicle:**

Make \_\_\_\_\_ Vehicle Model \_\_\_\_\_ Vehicle Year \_\_\_\_\_ License Number \_\_\_\_\_

**Other Driver's name:** \_\_\_\_\_ **Phone number:** \_\_\_\_\_

**Vehicle owner's name:** \_\_\_\_\_ **Phone number:** \_\_\_\_\_

(If different than driver)

**Insurance company:** \_\_\_\_\_ **Policy number:** \_\_\_\_\_

**WITNESS INFORMATION:** (If more than one witness, use another sheet of paper)

**Witness Name:** \_\_\_\_\_ **Signature:** \_\_\_\_\_ **Phone #:** \_\_\_\_\_

**Date:** \_\_\_\_\_ **Witness Statement** (use another sheet if needed): \_\_\_\_\_

**SUPERVISOR STATEMENT:**

**Name:** \_\_\_\_\_ **Signature:** \_\_\_\_\_

**Department:** \_\_\_\_\_ **Title:** \_\_\_\_\_

**Date:** \_\_\_\_\_ **Time:** \_\_\_\_\_ A.M. / P.M. **Work phone #:** \_\_\_\_\_

**How did the incident occur?** What were the actions, events and/or conditions that contributed to the incident? (use another sheet if needed) \_\_\_\_\_

**What are your recommendations or what actions have been taken to avoid similar incidents in the future?**

**Did this employee receive a drug test for this incident?**  Yes  No

**Will the employee miss work beyond the shift that he/she was injured**  Yes  No  Unknown

**Expected return to work date/full duty date?** \_\_\_\_\_

**If Fatality, date of death:** \_\_\_\_\_

**Work related injuries may qualify for the Family and Medical Leave Act (FMLA).**

Please refer to the FMLA policy: <https://humanresources.co.delaware.oh.us/wp-content/uploads/sites/15/2018/03/FMLA.pdf>