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
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:**
_____
_____
_____

Case # from PERRP 300P Log: _____ *Human Resources use only*

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 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