

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: _____
Job Title: _____
Address: _____ Date hired: _____
City: _____ State: _____ Zip: _____ Work phone #: _____
Date of Birth: _____ ☐ Male ☐ Female Time shift began: _____
Personal phone #: _____ Personal email: _____
Signature: _____ 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

Is PPE required for this task? ☐ Yes ☐ No What PPE was used: (list all) _____

What PPE was required: (list all) _____

HEALTH CARE OR PHYSICIAN INFORMATION:

Name of physician or first aid provider: _____

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>