

**CITY OF CHARLESTON
Report of Incident and Injury**

General Information	Employee Name: _____ Employee No.: _____																													
	Department: _____ Position: _____																													
	Supervisor: _____ Incident Date & Time: _____																													
	Address/Location of Incident: _____ Describe what the employee was doing immediately prior to the incident: _____ _____																													
Date & Time Employee Shift Began: _____																														
Incident Details	What equipment, substance or other object caused the incident: _____ _____																													
	Name of individual(s) first notified: _____																													
	Date & time notified: _____ List the name(s) of any witness* _____ _____																													
	<small>*Attach witness statement for each witness</small>																													
	Check Body Part(s) or Area(s) affected and circle R=right, L=left, B=both): (Please check all that apply) <table style="width:100%; border:none;"> <tr> <td><input type="checkbox"/> Ankle R L B</td> <td><input type="checkbox"/> Head</td> <td><input type="checkbox"/> Shoulder R L B</td> </tr> <tr> <td><input type="checkbox"/> Arm R L B</td> <td><input type="checkbox"/> Hip</td> <td><input type="checkbox"/> Thumb R L B</td> </tr> <tr> <td><input type="checkbox"/> Chest</td> <td><input type="checkbox"/> Internal</td> <td><input type="checkbox"/> Toes R L B</td> </tr> <tr> <td><input type="checkbox"/> Elbow R L B</td> <td><input type="checkbox"/> Knee R L B</td> <td><input type="checkbox"/> Trunk</td> </tr> <tr> <td><input type="checkbox"/> Eye R L B</td> <td><input type="checkbox"/> Leg R L B</td> <td><input type="checkbox"/> Upper Arm R L B</td> </tr> <tr> <td><input type="checkbox"/> Face</td> <td><input type="checkbox"/> Lower Arm R L B</td> <td><input type="checkbox"/> Upper Back</td> </tr> <tr> <td><input type="checkbox"/> Finger R L B</td> <td><input type="checkbox"/> Lower Back R L B</td> <td><input type="checkbox"/> Upper Leg R L B</td> </tr> <tr> <td><input type="checkbox"/> Foot R L B</td> <td><input type="checkbox"/> Lower Leg R L B</td> <td><input type="checkbox"/> Wrist R L B</td> </tr> <tr> <td><input type="checkbox"/> Groin</td> <td><input type="checkbox"/> Neck</td> <td><input type="checkbox"/> Other (describe below)</td> </tr> <tr> <td><input type="checkbox"/> Hand R L B</td> <td><input type="checkbox"/> Respiratory</td> <td></td> </tr> </table>	<input type="checkbox"/> Ankle R L B	<input type="checkbox"/> Head	<input type="checkbox"/> Shoulder R L B	<input type="checkbox"/> Arm R L B	<input type="checkbox"/> Hip	<input type="checkbox"/> Thumb R L B	<input type="checkbox"/> Chest	<input type="checkbox"/> Internal	<input type="checkbox"/> Toes R L B	<input type="checkbox"/> Elbow R L B	<input type="checkbox"/> Knee R L B	<input type="checkbox"/> Trunk	<input type="checkbox"/> Eye R L B	<input type="checkbox"/> Leg R L B	<input type="checkbox"/> Upper Arm R L B	<input type="checkbox"/> Face	<input type="checkbox"/> Lower Arm R L B	<input type="checkbox"/> Upper Back	<input type="checkbox"/> Finger R L B	<input type="checkbox"/> Lower Back R L B	<input type="checkbox"/> Upper Leg R L B	<input type="checkbox"/> Foot R L B	<input type="checkbox"/> Lower Leg R L B	<input type="checkbox"/> Wrist R L B	<input type="checkbox"/> Groin	<input type="checkbox"/> Neck	<input type="checkbox"/> Other (describe below)	<input type="checkbox"/> Hand R L B	<input type="checkbox"/> Respiratory
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Injury Source: (Please check all that apply) <table style="width:100%; border:none;"> <tr> <td><input type="checkbox"/> Automobile Accident</td> <td><input type="checkbox"/> Fall</td> <td><input type="checkbox"/> Repetitive Motion</td> </tr> <tr> <td><input type="checkbox"/> Burn</td> <td><input type="checkbox"/> Hand Tool(s)</td> <td><input type="checkbox"/> Slip or Trip</td> </tr> <tr> <td><input type="checkbox"/> Caught In/Under/Between</td> <td><input type="checkbox"/> Injured by Animal/Insect</td> <td><input type="checkbox"/> Sprain / Strain</td> </tr> <tr> <td><input type="checkbox"/> Cut / Puncture / Laceration</td> <td><input type="checkbox"/> Machine Injury</td> <td><input type="checkbox"/> Struck By/Against/Object</td> </tr> <tr> <td><input type="checkbox"/> Electric Shock</td> <td><input type="checkbox"/> Material Handling</td> <td><input type="checkbox"/> Struck By/Against/Person</td> </tr> <tr> <td><input type="checkbox"/> Equipment Accident</td> <td><input type="checkbox"/> Portable Power Tool(s)</td> <td><input type="checkbox"/> Other (describe below)</td> </tr> </table>	<input type="checkbox"/> Automobile Accident	<input type="checkbox"/> Fall	<input type="checkbox"/> Repetitive Motion	<input type="checkbox"/> Burn	<input type="checkbox"/> Hand Tool(s)	<input type="checkbox"/> Slip or Trip	<input type="checkbox"/> Caught In/Under/Between	<input type="checkbox"/> Injured by Animal/Insect	<input type="checkbox"/> Sprain / Strain	<input type="checkbox"/> Cut / Puncture / Laceration	<input type="checkbox"/> Machine Injury	<input type="checkbox"/> Struck By/Against/Object	<input type="checkbox"/> Electric Shock	<input type="checkbox"/> Material Handling	<input type="checkbox"/> Struck By/Against/Person	<input type="checkbox"/> Equipment Accident	<input type="checkbox"/> Portable Power Tool(s)	<input type="checkbox"/> Other (describe below)												
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Treatment	Medical Treatment: (Please check one) <input type="checkbox"/> On-site First-aid only <input type="checkbox"/> Urgent Care Facility <input type="checkbox"/> Emergency Room <input type="checkbox"/> Other (describe below)																													
	Name and location of medical facility (enter N/A if employee received no treatment): _____ _____																													
	Was the employee admitted to the medical facility? <input type="checkbox"/> Yes <input type="checkbox"/> No																													

Preparer's Name (print) _____

Preparer's Signature _____

Date _____

Employee's Signature _____

Date _____

By signing above, the employee does hereby authorize any person or persons who have in the past, or will in the future medically amend, treat or examine me or any person who may have information of any kind which may be used to arrive at a decision in any claim for injury or disease arising from the injury/illness described above, to disclose such information to the City, or any individual or entity authorized by the City. A copy of this form shall also serve as an original.

A completed report must be sent to Tim Campbell, Safety Coordinator no later than the end of the shift in which the incident/injury occurred, or as soon as reasonably possible if off-site medical treatment was obtained. Completed forms can be faxed or emailed to Tim Campbell at (304) 348-8055 or tim.campbell@cityofcharleston.org.

Revised July 2016