THE CITY OF Edinburg

MEMO REPORT OF INCIDENT/INJURY & SUPERVISOR'S INVESTIGATION REPORT

EMPLOYEE'S NAME: _____ **EMPLOYEE ID #:** _____

DEPARTMENT/DIVISION: _____ **JOB TITLE:** _____

DATE OF INCIDENT/INJURY: _____ **TIME OF INCIDENT/INJURY?** _____

THIS REPORT: ☐ **INJURY** ☐ **INCIDENT** ☐ **FIRST AID ONLY** ☐ **NEAR MISS** ☐ **VEHICLE ACCIDENT**

POLICE REPORT: YES ____ **NO**____ **POLICE REPORT #:** _____

IMPORTANT: *Any employee or volunteer that is involved/injured as a result of this incident/accident may be asked submit to Mandatory Drug & Alcohol test. The City has contracted with Drug Testing & More to be available 24/7/365. They can be reached at (956) 205-0103.*

Please contact Human Resources to determine if a Drug Test needs to be administered for this injury.

Was above employee administered a Post-Incident/Accident Drug & Alcohol Test: YES ☐ **NO** ☐

If **NO**, explain why: _____

DESCRIBE INCIDENT/INJURY: *(Explain the incident/injury. Identify causes to incident. Answer: Who, What, When, Where, Why and How?)*

_____

_____

IF INJURED, DESCRIBE THE INJURY AND INDICATE PART(S) OF BODY AFFECTED: *(Body Diagram needs to be attached)*

_____

IF INJURED, WAS ANY TYPE OF TREATMENT ADMINISTERED ONSITE? YES ☐ **NO** ☐

If **YES**, indicate type *(Ex: First Aid, Medication)*: _____

IF INJURED, WHEN WAS SUPERVISOR NOTIFIED OF INJURY? DATE: _____ **TIME:** _____ **AM/PM**

NAME AND ADDRESS IF WITNESS(ES): _____

_____

Consider the objective when answering the following statements: Eliminate job hindrances, accidents and injuries.

WHAT CHANGES ARE RECOMMENDED TO PREVENT FUTURE OCCURRENCES OF SIMILAR INCIDENTS?

☐ PURCHASE NEW EQUIPMENT ☐ REDESIGN THE ACTIVITY/TASK ☐ TRAIN THE EMPLOYEE(S) ☐ ENFORCE POLICY/PROCEDURE
☐ DEVELOP NEW POLICY/PROCEDURE ☐ ADDITIONAL PERSONAL PROTECTIVE EQUIPMENT ☐ ROUTINELY INSPECT FOR HAZARD
☐ OTHER_____ ADDITIONAL COMMENTS: _____

EXPLAIN CORRECTIVE ACTION TAKEN AND HOW IT WILL IMPROVE OPERATIONS: (*work order, training, disciplinary action, etc.)*

_____

FOLLOW-UP: WAS THE ACTION TAKEN EFFECTIVE?

_____

HAS EMPLOYER'S FIRST REPORT OF ACCIDENT (DWC 1) BEEN FILED ON EMPLOYEE? ☐ **YES** ☐ **NO** ☐ **NOT NECESSARY**

I (Employee) Refuse Medical Treatment at this time: _____ **Date:** _____

Supervisor Name: _____ **Title:** _____

Supervisor Signature: _____ **Date:** _____

Reviewed by Risk Manager: _____ **Date:** _____

Note: Completed report is to be submitted to Human Resources - Risk Management. If employee is absent from work for more than one day (not counting the day of the injury; goes to a doctor or hospital; and/or receives medication, you must also complete the "Employer's First Report of Injury" (DWC-1) form and submit it promptly to Risk Management for processing. If a Memo Report of Injury has been filed regarding this injury and the employee later requires medical attention, promptly submit the DWC-1, with a notation that a Memo Report of Injury was previously submitted.