DAWSON COUNTY (Non-Employee)
INCIDENT/ACCIDENT/INJURY INVESTIGATION REPORT FORM

Instructions

1. Report to be completed by injured party immediately.
2. Injured party must complete Part I and Department Head where injury occurred complete Part II (Supervisor: Make 2 copies: 1 for safety/insurance and keep 1 copy for your files)
3. Forward Original to the Payroll Administrator (Payroll Adm needs to notify liability insurance co, keep a copy and forward the original to the Safety Director.

Part I ***- To be Completed by the Injured Party (Or Supervisor of Dept where accident occurred if the injured party is not able to complete)***

Injured Person's Name:

Date of Injury: Time of Injury: a.m/p.m.

Place of Injury: (Specific location)

Was this on Dawson County's Premises? ☐ Yes ☐ No If No, Stop, contact the owner or proper law enforcement

Specify the address:

Name(s) of all witness(es) to your injury:

Names of other party(s) involved:

How did the injury occur (describe what happened):

What body part was affected: (head, arm, leg, back, etc.)

Extent of injury:

Was first aid administered: ☐ Yes ☐ No Did you require professional medical care: ☐ Yes ☐ No

If Yes, Hospital Doctor: Date of Visit:

Address of Doctor/Hospital: Phone Number:

Initial Treatment: ☐ None ☐ Emergency Room ☐ On Site by Employer/Med Staff ☐ Clinic/Dr ☐ Hospital

Was an overnight stay in the hospital required: ☐ Yes ☐ No

Were you off work because of this accident: ☐ Yes ☐ No If yes, 1st work day off, date:

Object or activity that directly caused the injury:

Was the injury caused by a failure of machine or product: ☐ Yes ☐ No Explain:

If applicable, was safety equipment provided: ☐ Yes ☐ No

Who did you report incident/accident to:

Was safety equipment used: ☐ Yes ☐ No

How could this incident/accident have been avoided:

Injured Party's Signature: **Date:**

(If a vehicle was involved also complete "Vehicle Accident/Collision Report" form)

Part II - ***To Be Completed by the Supervisor of Dept where accident occurred***

Person's physical condition prior to incident/accident: ☐ Apparantly normal ☐ Other

If other, please explain:

Did you witness the incident/accident: ☐ Yes ☐ No

Describe accident, include the machine, object or substance involved:

What caused the incident/accident:

What could be done to prevent injuries of this type:

Corrective action taken:

Supervisor Signature: **Date:**

Part III ***- To Be Completed by Safety Director & Safety Committee Members***

Summary of investigation:

Additional Corrective action proposed:

Further recommendations:

Complete Date:

Safety Director Signature: **Date:**

Committee Member Signature: **Date:**