CITY OF WATERTOWN
INCIDENT/INJURY REPORT

TO BE COMPLETED BY INJURED EMPLOYEE WITHIN 24 HOURS

If an injury affects the ability of an employee to complete this form, the immediate supervisor should proceed with the remainder of the forms in this packet and submit them to the Office of the Clerk/Treasurer. The employee must provide their narrative of the events as soon as he/she is able.

Employee Information:

Name:			Date of Birth:
Home Address:			Home/Cell Phone Number:
Job Title:	Current Rate of Pay:	Normal Work Hours:	Date of Hire (If known):

Injury/Incident Information:

Date of Injury:	Time of Injury ◯ AM ◯ PM	Exact Body Part Affected (ex: left index finger):

Address Where Injury/Incident Occurred: City: ZIP Code:

Describe in your own words exactly what you were doing at the time this injury/incident occurred and any other information that may relate to the incident/injury and its cause (attach additional pages if needed):

Did you work the full date of injury? ◯ Yes ◯ No

Will you miss time from work for this injury? ◯ Yes ◯ No If yes, list estimated return date:_____

Were there any witnesses to this injury? ◯ Yes ◯ No If yes, list:_____

Do you intend to visit a doctor at this time? ◯ Yes ◯ No If yes, list clinic or doctor name:_____

Prior to all non-emergency medical appointments for this injury, you must obtain a form from the City Clerk's office to be completed by your doctor.

In your opinion, was this accident due to lack of safety equipment or standards? ◯ Yes ◯ No

If yes, please describe:

This report must be filed with your department head within 24 hours of an injury or incident that may result in an injury, or as soon as possible thereafter. In the case of an injury that will result in lost time from work, keep your department head and the Clerk/Treasurer's office informed at all times of your condition and ability to return to work. Failure to report this information may result in delayed worker's compensation benefits.

Employee Signature: _____ Date: _____

CITY OF WATERTOWN
SUPERVISOR'S REPORT ON INCIDENT/INJURY
TO BE COMPLETED BY SUPERVISOR OF INJURED EMPLOYEE

Name of Injured Employee:		Date Employee Informed You of Injury:
Supervisor Name:	Supervisor Title:	Supervisor Daytime Phone:
Describe the injury/incident:		
Describe the cause of injury/incident:		
What action will be taken to prevent recurrence of this type of injury/incident?		
Will the injury or incident result in lost work time? ◯ Yes ◯ No		
What safety equipment, if any, was in use at the time of the injury/incident?		
List any additional comments or concerns regarding this injury/incident:		

Supervisor Signature: _____ Date: _____

Department Head Signature: _____ Date: _____
If Supervisor is not Department Head

Rev. 4/9/15

CITY OF WATERTOWN
WITNESS REPORT ON INCIDENT/INJURY
TO BE COMPLETED BY ALL WITNESSES

Name of Injured Employee:		Date of Injury:
Witness Name:	Witness Title:	Witness Daytime Phone:
Describe the injury/incident:		
Describe the cause of this injury/incident:		
Do you have a recommendation on how to prevent recurrence of this type of injury/incident?		
What safety equipment, if any, was in use at the time of the injury/incident?		
List any additional comments or concerns regarding this injury/incident:		

Witness Signature: _____ Date: _____

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CITY OF WATERTOWN
WITNESS REPORT ON INCIDENT/INJURY
TO BE COMPLETED BY ALL WITNESSES

Name of Injured Employee:		Date of Injury:
Witness Name:	Witness Title:	Witness Daytime Phone:
Describe the injury/incident:		
Describe the cause of this injury/incident:		
Do you have a recommendation on how to prevent recurrence of this type of injury/incident?		
What safety equipment, if any, was in use at the time of the injury/incident?		
List any additional comments or concerns regarding this injury/incident:		

Witness Signature: _____ Date: _____

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