EMPLOYEE'S REPORT OF ACCIDENT OR INJURY
CITY OF LACONIA

To be completed by employee directly involved in personal injury or equipment accident.

PLEASE PRINT. THIS FORM WILL BE USED TO FILL OUT REQUIRED FORMS.
DO NOT LEAVE ANY INFORMATION BLANK.

DATE OF THIS REPORT: _____

☐ INJURY ☐ VEHICLE / EQUIPMENT ☐ EXPOSURE

NAME:_____ DEPARTMENT_____

JOB TITLE: _____ DATE OF HIRE: _____

HOME ADDRESS:_____
Street/PO Box City Zip Code

HOME TEL NUMBER:_____ SOCIAL SECURITY NO:_____

DATE OF BIRTH:_____

DATE AND TIME OF INCIDENT: _____ A.M./P.M. _____

LOCATION OF INCIDENT (*Exact*): _____

IF MOTOR VEHICLE OR EQUIPMENT: VEHICLE ID NUMBER _____

PLATE NUMBER: _____ WAS ANYONE INJURED? ☐ YES ☐ NO

IF YES: NAME:_____
ADDRESS:_____

INITIAL TREATMENT: ☐ NONE ☐ ON SITE ☐ EMERGENCY ROOM

☐ LAKES REGION OCCUPATIONAL HEALTH ☐ OTHER _____

NAME OF TREATING PHYSICIAN: _____

NAME OF TREATING HOSPITAL: _____

WILL YOU LOSE TIME FROM WORK? IF YES, LIST DATES:_____

(over)

DESCRIBE FULLY HOW ACCIDENT OCCURRED – WHAT YOU WERE DOING; MACHINE OR EQUIPMENT BEING USED; WHERE DID IT HAPPEN - ON GROUNDS, IN BUILDING (IDENTIFY); PART(S) OF BODY INJURED.

_____
_____
_____
_____
_____
_____
_____

WHAT ACTION WILL YOU TAKE TO PREVENT THIS OR A SIMILAR INCIDENT FROM OCCURRING IN THE FUTURE:

- ☐ Seek additional training
- ☐ Be more aware
- ☐ Caution other employees about this situation
- ☐ Recommend an adjustment of the equipment involved
- ☐ Other _____
  _____

IS THIS YOUR FIRST ACCIDENT? ☐ YES ☐ NO

WITNESS (ES):_____

NAME(S) AND ADDRESS(ES)_____
_____

EMPLOYEE SIGNATURE:_____

NAME OF SUPERVISOR YOU NOTIFIED:_____

DATE: _____

PLEASE GIVE TO YOUR SUPERVISOR IMMEDIATELY; IF YOU CANNOT, PLEASE CONTACT THE PERSONNEL OFFICE AT 524-3877 OR FAX TO 524-1520.

Revised May 2005