Mark A. Hackel
County Executive

Employee Incident Report Form

FORM MUST BE COMPLETELY FILLED OUT

Form should be filled out by injured employee. If injured employee is unable to fill out form within specified time period, the immediate supervisor should fill it out to the best of his/her ability. Please use your discretion.

☐ Check box if completing form FOR injured employee

Section 1: EMPLOYEE INFORMATION

Employee Name: _____ Date of Birth: _____

Home Address: _____ Telephone Number: _____

Job Title: _____ Department: _____ Employee ID #: _____

Check All That Applies: Full Time ☐ Part Time ☐ Temporary ☐ Contract Employee ☐

Section 2: INCIDENT INFORMATION

Incident Date: _____ Time of Incident: _____ am/pm Time Shift Began: _____ am/pm

Incident Reported to: _____ Date/Time Incident Reported: _____

Part of Body Injured (specific): _____

Type of Accident:

☐ Slip/Trip/Fall ☐ Extreme Temperature ☐ Repetitive Motion ☐ Material Handling

☐ Cuts/Sharps ☐ Striking an Object ☐ Abrasion/Bruise ☐ Blood Borne Exposure

☐ Other: _____

Injured on County Proper- ☐ ty: ☐ Yes No (Specify Address) _____

Incident Location (i.e. lobby, hallway, etc): _____

Action Taken: ☐ First Aid ☐ Employer Clinic ☐ Hospital (Specify) _____

# of Employees Involved: _____ # Injured/Ill: _____ # Fatalities: _____

How Did the Incident Occur. List safety equipment in use (if any) and specifics as to how the injury occurred. Attach photos, sketches, and/or second page if necessary.

_____

_____

_____

_____

_____

_____

_____

SECTION 3: WITNESS INFORMATION (If, any)

Witnesses (Name & Phone Number): _____

WITNESS (If Any) Please Fill Out Supplemental Witness Form

Section 4: CORRECTIVE ACTIONS (To be filled out by immediate supervisor)

What Action Can Be Taken to Prevent Incident Reoccurrence?

- ☐ Equipment/Machinery Modification or Maintenance
- ☐ Improve Design/Construction
- ☐ Change to Work Procedure
- ☐ Improve Housekeeping
- ☐ Improve Work Organization
- ☐ Improve Personal Protection
- ☐ Enhance Training and Instruction
- ☐ Use of Safer Material
- ☐ Re-Training
- ☐ Other: _____

Specify Measures Already Taken: _____

Comments: _____

Section 5: SIGNATURES

Name of Immediate Supervisor (Printed): _____ Phone #: _____

Signature of Immediate Supervisor: _____ Date: _____

Name of Department Head: _____ Phone #: _____

Signature of Department Head: _____ Date: _____

AUTHORIZATION FOR PATIENT RECORDS

I, the undersigned, do hereby authorize by my signature on this injury and illness report, any hospital, physician, or other person who has attended me or examined me regarding the injury/illness described above to furnish the County of Macomb, or its representative any and all information with respect to this injury/illness and medical history, consultation, prescription, or treatment, and copies of all hospital or medical records of prior injuries/illnesses similar to this one. A photostatic copy of this Authorization shall be considered as effective and valid as the original.

Signature of Employee: _____ Date: _____

Please immediately scan and email these documents to:
employeeincidentreport@macombgov.org or fax them to (586)469 6974 **and** forward the originals via interoffice mail to Human Resources and Labor Relations.
These forms must be returned IMMEDIATELY after completion or within 24 hours of Incident