Lincoln County
Incident Report

Page One Instructions

To be filled out by injured employee. If employee is unavailable, supervisor must complete on employee's behalf.

Personal Information

First name: (Print)	**M.I.:**	**Last Name: (Print)**
Home Address:		**Home Phone/Cell:**
Email Address:		**Number of Dependents:**
Date of Birth:	**Marital Status:**	**Gender:**

Work Information

Department Address:		**Work Phone #**
Job Title:	**Emp ID:**	**Time Work Began:** AM/PM
Time of Supervisor Notification: AM/PM	**Supervisor Name:**	

Incident Information

Incident Address/Location:

Date & Time of Event:

Incident Type: **Mark all that apply.**

* Animal related:	* Fall from elevated height:	* Struck By:
* Assault:		* Vehicle related:
* Blood Exposure:	* Overexhertion:	
* Ergonomics:	* Poisioning:	
* Exposure/Other:	* Slips:	* Other:
* Fall from ground height:	* Sprain/Strain:	
	* Struck Against:	

Injury Information

Injury Type: **Mark all that apply.**

Head:	R-Forearm:	L-Leg:	Fingers:
Neck:	L-Forearm:	R-Leg:	
Torso:	R-Elbow:	L-Knee:	
R-Arm:	L-Elbow:	R-Knee:	Specify what finger is injured.
L-Arm:	Lower Back:	L-Foot:	i.e. L-Index, R-Thumb, etc.
R-Hand:	Upper Back:	R-Foot:	
L-Hand:	Pelvic Area:	Other:	

Vehicle Information

Vehicle Details: **Complete this section if a county vehicle was involved.**

Driver License #:		**Vin #:**
License Plate #:	**Seat belt used?**	**Make:**
Model:	**Year:**	**Responding Law Enf. Agency**
Location detail: (Cross-roads)		

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Page Two Instructions

To be filled out by injured employee. If employee is unavailable, supervisor must complete on employee's behalf.

Employee Statement

State the who, what, when, where, why & how.

Employee Name: (Print)	**Refused Medical Treatment?** Yes / No
Signature:	**Date:**

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Page Three Instructions

To be completed by the injured employees supervisor or manager.

Supervisor Statement

State the who, what, when, where, why & how.

Was First-Aid given?	Yes No	**Provide name of who gave First-Aid:**
Employee Sent to Hospital?	Yes No	**If Yes, Provide name of Facility:**
Time employee went to facility:	AM PM	**Date employee went to facility:**

Supervisor Name: (Print)	**Phone Number:**
Signature:	**Date:**

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Page Four Instructions

To be completed by the injured employees supervisor or manager.

Preventive Measures

Was a policy set in place?	Yes No	**If yes, briefly describe.**
Any unsafe acts that led to the injury?	Yes No	**If yes, briefly describe.**
Was policy violated?	Yes No	**If yes, briefly describe.**
Any unsafe conditions that led to the injury?	Yes No	**If yes, briefly describe.**

Any preventive measures discussed? (Do not leave blank)

Attachments

Please list any supporting documents attached to the report.

Reporting Supervisor:		**Workers Comp Reviewing Authority:**	
First:		**First:**	
Last:		**Last:**	
Department:		**Department:**	
Position:		**Position:**	
Date:	**Time:**	**Date:**	**Time:**
Signature:		**Signature:**	

Is this a Safety Committee Concurrence? **Yes** **No**

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Page Five Instructions

To be completed by the witness.

Witness Statements

All fields must be completed.

Witness Name: (Print)

Address:

Phone Number: | **Email Address:**

Statement:

Signature: | **Date:**

All fields must be completed.

Witness Name: (Print)

Address:

Phone Number: | **Email Address:**

Statement:

Signature: | **Date:**