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:**
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)		

Lincoln County
Incident Report

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?** No
Signature:	**Date:**

Lincoln County
Incident Report

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? No	**Provide name of who gave First-Aid:**
Employee Sent to Hospital? 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:**

Lincoln County
Incident Report

Page Four Instructions

To be completed by the injured employees supervisor or manager.

Preventive Measures

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

Lincoln County
Incident Report

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:**