Personal Injury Report

Please email a completed copy to risk.management@maconbibb.us

Department _____ Division _____

Accident Date _____ Accident Time_____ AM___ PM ___

On County Premises () Yes () No Date Employee First Aware_____

Exact Location of Accident/Incident_____

Person Involved_____ Employee Position/Title _____

Home Address _____ City, State, Zip Code_____

Date of Birth _____ () Male () Female Marital Status _____

Home/Cell Telephone _____ Work _____

Part of Body Affected_____

Accident Reported to_____

Hospitalized () Yes () No Treatment by _____

First Full Day out of work _____First Full Day back to Work _____

Work Hours/Schedule _____

Safety Restraints Utilized (if applicable) No ____ Yes ____ If yes, describe_____

_____

Witness Name_____ Contact Number_____

This section must be completed by the EMPLOYEE:

Describe exactly what happened: (Before, during and After the Accident/Incident)

_____

_____

_____

This section must be completed by the employee's IMMEDIATE SUPERVISOR:

What will you do to prevent this type of accident from happening again?

_____

_____

_____

Employee Signature: _____ **Date:** _____

Immediate Supervisor: _____ **Date:** _____

Division Head: _____ **Date:** _____