EMPLOYEE INCIDENT REPORT

DEPARTMENTS:

1) *For serious injuries,* ***immediately*** *notify Human Resources.*
2) ***Check box*** for employee's work status at time report submitted:
   - ☐ Regular duty
   - ☐ Modified/light duty as of _____
   - ☐ Out of work as of _____

Print form to fill in, then email completed copy to **EIR@providenceri.gov** within 48 hours of incident.

OR

Download form to fill in, then email completed form to **EIR@providenceri.gov** within 48 hours of incident.

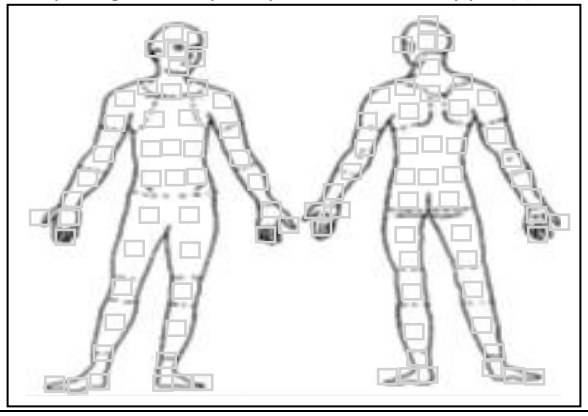
EMPLOYEE INFORMATION: *(To be completed by employee)*		
Last Name:	First:	MI:
DOB:	Gender:	
Home Address:		
City:	State:	Zip:
Work Phone:	Cell Phone:	Home Phone:
Department:	Job Title:	
Date of Hire:	Time Workday Starts:	AM/PM

DETAILS OF THE INCIDENT:		
Date of Incident:	Time of Incident:	AM/PM
Where did the incident occur: *(Name of street, building, office, etc.* ***Be specific****.)*		
What task were you performing at the time of the incident:		
In detail, describe how it happened: *(List any object/substance/truck, vehicle or equipment involved)*		

Did an injury occur? _____Yes _____ No

If Yes, list what parts of your body were involved. (Be specific such as left knee, right hand, etc.)

Insert check mark to indicate involved body part(s)s on the diagram or, if completing online, place your cursor on body part(s) and click.



Were you wearing Personal Protective Equipment (PPE)? Explain.

Did you seek medical treatment? Check the appropriate box:

☐ First Aid Only

☐ Outside Medical Treatment

List name of physician/treatment center _____

☐ No treatment needed at this time.

*NOTE: If you decide to seek medical treatment **after** filing this report, immediately notify the Workers' Compensation Division in Human Resources or you may be incorrectly charged copayments.*

Were you released to your regular job? _____ Yes _____ No

Were you released to modified/light duty? _____ Yes _____ No

If cleared for light duty, please give the restrictions:

List all witnesses and others in the area at the time the incident occurred.

To whom did you report the incident?

When did you report it?

I certify that the information contained in this report is true and correct. I understand that any falsification of information regarding an on the job injury may result in disciplinary action and/or action permissible pursuant to the Rhode Island Workers' Compensation statute.

_____ _____

Employee's Signature **Date**

SUPERVISOR'S INFORMATION :

What was the employee doing at the time of the incident? Did you talk with them directly?

Was the employee following standard procedures at time of incident? Explain.

Was there a violation of department safety practices? Explain.

Have you interviewed all other persons present? If witness statement not attached, please identify individuals and summarize their statements.

Is there anyone you have NOT interviewed? Explain.

What can be done to prevent similar incidents?

What have you done to communicate with your staff about how to prevent this from happening again?

_____ _____

Supervisor's Signature **Date**