

**CITY OF HICKORY  
INJURY REPORT**

**RETURN TO HUMAN RESOURCES  
TO BE COMPLETED BY INJURED COWORKER ONLY!**

**If injury is the result of a vehicle accident,  
complete both sides of form.**

**\*\*\*\*\*SUBMIT THIS REPORT WITHIN 24 HOURS FROM TIME OF ACCIDENT/INCIDENT/INJURY\*\*\*\*\***

**PLEASE PRINT**

**INJURY/INCIDENT INFORMATION**

DATE OF ACCIDENT	TIME OF ACCIDENT	ADDRESS OF ACCIDENT	IF INSIDE BUILDING, LOCATION WITHIN BUILDING
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NAME-LAST	FIRST (M)	DATE OF BIRTH	DATE OF HIRE
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DEPARTMENT	POSITION TITLE	NAME OF IMMEDIATE SUPERVISOR
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NAME OF SUPERVISOR NOTIFIED	DATE AND TIME SUPERVISOR NOTIFIED	DID YOU VISIT? CITY NURSE <input type="checkbox"/>	DRUG TEST <input type="checkbox"/> Yes <input type="checkbox"/> No	WERE YOU EXPOSED TO BLOOD OTHER THAN YOUR OWN? YES <input type="checkbox"/> NO <input type="checkbox"/>
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WITNESSES:	DOCTOR <input type="checkbox"/>	
	ER(LOCATION) <input type="checkbox"/>	
	NONE <input type="checkbox"/>	

**LIST THE NAMES OF ANY OTHER COWORKERS INJURED (EACH PERSON MUST COMPLETE A SEPARATE REPORT):**

LAST NAME	FIRST (M)
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**PERSONAL PROTECTIVE EQUIPMENT OR SAFETY EQUIPMENT BEING USED AT THE TIME OF THE INJURY:**

<input type="checkbox"/> SAFETY GLASSES	<input type="checkbox"/> GAS DETECTOR	<input type="checkbox"/> OTHER (SPECIFY)
<input type="checkbox"/> RESPIRATOR	<input type="checkbox"/> SEAT BELT	_____
<input type="checkbox"/> MASK	<input type="checkbox"/> HARD HAT	_____
<input type="checkbox"/> HEARING PROTECTION	<input type="checkbox"/> GLOVES (LEATHER, LATEX, KEVLAR, ETC.)	_____
<input type="checkbox"/> SAFETY BOOTS/SHOES	<input type="checkbox"/> FLAGGING, SIGNAGE, BARRICADES IN PLACE	_____
<input type="checkbox"/> SAFETY VEST	<input type="checkbox"/> CHAPS	_____

**ACCIDENT/INCIDENT INJURY DESCRIPTION:**  
DESCRIBE FULLY HOW INJURY OCCURRED AND WHAT EMPLOYEE WAS DOING WHEN INJURED:

LIST SPECIFIC BODY PART(S) INVOLVED (EXAMPLE: RIGHT HAND, LEFT LEG, ETC.):

INJURY OTHER THAN CITY COWORKER (CITIZEN, ETC.):

ADDITIONAL COMMENTS (INJURED COWORKER ONLY):

**DECLARATION:**  
I CERTIFY THAT MY STATEMENTS MADE IN THIS REPORT ARE TRUE, COMPLETE, AND CORRECT TO THE BEST OF MY KNOWLEDGE AND BELIEF AND ARE MADE IN GOOD FAITH. I AUTHORIZE INVESTIGATION OF ALL STATEMENTS MADE IN THIS REPORT. I UNDERSTAND THAT FALSE INFORMATION MAY BE GROUNDS FOR DISMISSAL. IF I WAS UNABLE TO COMPLETE THIS FORM, I CERTIFY I DIRECTED THE PERSON LISTED BELOW TO COMPLETE THE FORM BASED ON MY ANSWERS.

COWORKER SIGNATURE	DATE
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**IF COWORKER DID NOT COMPLETE THIS FORM:**

IF COWORKER DID NOT COMPLETE THIS FORM, EXPLAIN WHY:

WHO COMPLETED THE FORM FOR THE COWORKER?  
I CERTIFY ALL QUESTIONS AND ANSWERS HAVE BEEN READ TO ME AND THESE ARE MY STATEMENTS

\_\_\_\_\_  
SIGNATURE OF INJURED COWORKER

ADDITIONAL INFORMATION ATTACHED

**VEHICLE/EQUIPMENT ACCIDENT OR PROPERTY DAMAGE**

**IF COWORKER WAS INJURED, COMPLETE,  
BOTH SIDES OF FORM.**

**TO BE COMPLETED BY COWORKER ONLY!**

**\*\*\*\*\*SUBMIT THIS REPORT WITHIN 24 HOURS FROM TIME OF ACCIDENT/INCIDENT/INJURY\*\*\*\*\***

**PLEASE PRINT**

**INCIDENT INFORMATION**

DATE OF ACCIDENT	TIME OF ACCIDENT	ADDRESS OF ACCIDENT	
NAME-LAST	FIRST	(MI)	DATE OF BIRTH
DEPARTMENT		POSITION TITLE	NAME OF IMMEDIATE SUPERVISOR
NAME OF SUPERVISOR NOTIFIED	DATE AND TIME SUPERVISOR NOTIFIED	DRUG TEST YES <input type="checkbox"/> NO <input type="checkbox"/>	NAME OF RESPONDING LAW ENFORCEMENT AGENCY
WITNESSES:			
Description of Accident (when no injury)			

**PROPERTY DAMAGE:**

PROPERTY OWNER-LAST NAME	FIRST	(MI)	TELEPHONE NUMBER	ADDRESS
DESCRIPTION OF DAMAGES/STOLEN PROPERTY				
VIN # OF CITY VEHICLE	SERIAL # ETC OF EQUIPMENT		VIN # OF OTHER VEHICLE	OTHER PROPERTY DAMAGE (Ex. Fence, mailbox, etc.)

**ADDITIONAL COMMENTS:**

**SIGNATURE:**

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COWORKER	DATE
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ADDITIONAL INFORMATION ATTACHED

**SUPERVISOR QUESTIONS/COMMENTS**

DID COWORKER RETURN TO WORK?	IF SO, DATE	TIME
TIME COWORKER BEGAN WORK?	NUMBER OF HOURS SCHEDULED TO WORK	
WHO WAS RESPONSIBLE FOR THE JOB SITE? WAS THE COWORKER INTERVIEWED REGARDING THE ACCIDENT? IF SO, WHEN WERE THEY INTERVIEWED?		
CORRECTIVE ACTION – HOW COULD THIS INCIDENT HAVE BEEN AVOIDED? WHAT CHANGES WILL BE MADE? (Example: Were policies or procedures not followed, was the Equipment faulty, was there lack of supervision, was there lack of training, etc.?)		
WAS THIS CORRECTIVE ACTION COMMUNICATED TO THE COWORKER?		
WHAT DISCIPLINARY ACTION WAS TAKEN? (This should be on a Personnel Action Form).		
IF NO DISCIPLINARY ACTION WAS TAKEN, EXPLAIN WHY.		
OTHER COMMENTS OR INFORMATION:		

**WHAT PERSONAL PROTECTIVE EQUIPMENT OR SAFETY EQUIPMENT WAS BEING USED.**

<input type="checkbox"/> SAFETY GLASSES	<input type="checkbox"/> GAS DETECTOR	<input type="checkbox"/> OTHER (SPECIFY)
<input type="checkbox"/> RESPIRATOR	<input type="checkbox"/> SEAT BELT	_____
<input type="checkbox"/> MASK	<input type="checkbox"/> HARD HAT	_____
<input type="checkbox"/> HEARING PROTECTION	<input type="checkbox"/> GLOVES (LEATHER, LATEX, KEVLAR, ETC)	_____
<input type="checkbox"/> SAFETY BOOTS/SHOES	<input type="checkbox"/> FLAGGING, SIGNAGE, BARRICADES IN PLACE	_____
<input type="checkbox"/> SAFETY VEST	<input type="checkbox"/> CHAPS	_____

WAS THIS EQUIPMENT BEING USED CORRECTLY?

**SIGNATURE:**  
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INVESTIGATING SUPERVISOR	DATE	DEPARTMENT HEAD	DATE
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ADDITIONAL INFORMATION ATTACHED