SHELBY COUNTY GOVERNMENT

INCIDENT/INJURY REPORT

PLEASE PRINT:

Name | SSN | Date of Birth | Job Title

Employee Home address | City | Zip Code | Department | Shift Time

Employee Home phone Number | Witness | Witness Phone Number

Date Injured | Time (AM/PM?) | Date Reported to Supervisor | Time (AM/PM?)_____

Description of Injury/Incident: Report to be completed by immediate Supervisor. Give FULL details. What happened, where incident happened; Type of Injury (ie: Contusion, Fracture, Left or Right, etc.) Use additional sheet if needed.

Narrative completed by: Employee_____Supervisor_____(If by Supervisor, please state: "Injured worker stated……..")

Returned to work? Y N Sent to Emg Rm Y N Minor Med Y N Relieve of Duty? Y N

Medical Facility Name and Address

It is a crime to knowingly provide false, incomplete or misleading information to any party of an on the job injury transaction for the purpose of committing fraud. Penalties include imprisonment, fines, termination and denial of benefits.

I understand and agree that if I have been injured in an accident in which a third party (other than Shelby County Government or myself) should be held responsible, Shelby County Government is entitled to recover from that third party any amounts that have been paid on my behalf, including but not limited to salary, OJI benefits, and medical payments.

Employee Signature | Work Phone Number | Date of Hire | Today's Date

Supervisor Signature | Supervisor Name Printed | Work Phone Number | Today's Date

Risk Management Use Only

Claim #W_____