| | | |
|---|---|---|
| **ACCIDENT/INCIDENT REPORT** | **To be completed by Supervisor and submitted to risk@leaguecitytx.gov within 24 hours** | Initial Report |

**Check Type:**

☐ Workers comp. (Claim), complete Sections 1, 2, 5, 6
☐ Liability Claim, complete Sections 1, 4, 5, 6
☐ Property/Equipment (Claim), complete Sections 1, 3, 4, 5, 6
☐ Motor Vehicle Claim, complete Sections 1, 3, 4, 5, 6

**Check Notification:**

Notified Police: ☐ Yes ☐ No
Required for all Auto Accidents /Property Damage

Notified Department Designee: ☐ Yes ☐ No
Required for all Auto Accidents /Property Damage

Notified HR: ☐ Yes ☐ No

**SECTION 1 BASIC INFORMATION**

Employee/Citizen Name:_____ Employee ID Number (if applicable):_____
Department:_____ Date of Incident: _____
Supervisor Name:_____ Time of Incident:_____a.m._____p.m.
Supervisor Phone & Ext.: _____ Time Shift Started: _____a.m._____p.m.
Supervisor Cell Phone: _____ Day of Week: _____
Date Reported to Supervisor:_____
Location/Address of Incident:_____

**SECTION 2. WORKERS' COMPENSATION**

Employee's Home Address: _____
City:_____ State:_____ Zip:_____ County:_____
Home Phone:_____ Phone# where employee can be reached:_____
Treating Doctor (if known) _____
Clinic/Hospital: _____ Phone: _____
Address: _____ City:_____ State: _____ Zip:_____
Nature of Injury:_____ Cause of Injury: _____
Part of body injured: _____
Employee Refused Medical Treatment: Yes ☐ No ☐ Medical Treatment Received: Yes ☐ No ☐
Was there any loss of time? Yes ☐ No ☐ If yes, date loss of time started: _____

**SECTION 3. CITY VEHICLE ACCIDENT/PROPERTY/EQUIPMENT DAMAGE**

Describe damage:

Year ☐ Make: ☐ Model: ☐ VIN: ☐ Vehicle #: ☐
Police called? Yes ☐ ☐ Police report Number: ☐ Vehicle Towed: Yes ☐ No ☐

**SECTION 4. VEHICLE/PROPERTY DAMAGE (NOT CITY)**

Owner of vehicle/property:_____ Driver of Vehicle: _____
Address or Location: _____
City:_____ State:_____ Zip:_____ County: _____
Year:_____ Make:_____ Model:_____ Vehicle License Number: _____
Driver's Insurance Company:_____ Policy Number:_____

**SECTION 5 COMPLETE FOR ALL ACCIDENTS**

Witness Name, Address, Contact Phone: _____
Witness Name, Address, Contact Phone: _____

| SECTION 6 | SUPERVISOR'S INVESTIGATIONREPORT |
|---|---|

**What happened?** *Describe what took place or what caused you to conduct this investigation*. **Why did it happen?** Get all the facts by studying the job and situation involved. **What have you done thus far?** Take or recommended action, depending upon your authority.

**Alcohol & Controlled Substance Policy:**

Employee Drug Screen: ☐ Yes ☐ No

Employee's signature: _____ Date: _____

Supervisor's signature: _____ Date: _____

**email completed form to: risk@leaguecitytx.gov**

**Leave this area blank to be completed by Human Resources**

| | | |
|---|---|---|
| Did the action(s) of another cause/contribute to the incident? Yes ☐ No ☐. If yes, list: | Was the Accident Caused by any of the below factors: | |
| | Operator Error: ☐ Yes ☐ No | Equipment: ☐ Yes ☐ No |
| Was personal protective equipment in use? Yes ☐ No ☐ | Environmental: ☐ Yes ☐ No | Weather: ☐ Yes ☐ No |
| Was a seat belt worn? Yes ☐ No ☐ | | |

CLEAR FORM