CITY AND COUNTY OF BROOMFIELD
ACCIDENT/INJURY REPORT (PAGE 1 OF 3)

1) Use this form to report accidents or injuries on City and County property or while working or attending a City and County-approved function.
2) Complete this report within 1 working day after the accident/injury and forward copies to the administrative office of your department and the Human Resources Department.
3) If the accident/injury involves a City and County employee or City and County property, the supervisor must also complete the ***SUPERVISOR'S INVESTIGATION REPORT*** on reverse side of this form.
4) Injured employees must complete a Workers' Compensation ***FIRST REPORT OF INJURY*** form (available in Human Resources Department) within 48 hours of injury. PROMPT REPORTING OF WORK-RELATED INJURIES IS A REQUIREMENT OF FEDERAL AND STATE LAW. FAILURE TO REPORT AN INJURY PROMPTLY CAN DISQUALIFY THE INJURED EMPLOYEE FROM ELIGIBILITY FOR COMPENSATION. REFER TO THE CITY AND COUNTY'S SAFETY MANUAL FOR SPECIFIC INSTRUCTIONS. If the employee is incapacitated, the immediate supervisor must complete the form for the employee.

ACCIDENT/INJURY DATE:	Time:	☐ AM ☐ PM	DATE REPORTED:

WHERE DID ACCIDENT/INJURY OCCUR (LOCATION)?

EXPLAIN HOW ACCIDENT/INJURY OCCURRED:

CORRECTIVE MEASURES RECOMMENDED:

NAME(S) OF WITNESS(ES) – Request that each witness complete a ***WITNESS STATEMENT FORM*** (attached to this form).

********** **COMPLETE THE FOLLOWING SECTION ONLY IF ACCIDENT INVOLVED INJURIES** **********

INJURED PERSON'S NAME:	DOB:	PHONE NO:	(H)	(W)

ADDRESS:

DESCRIBE INJURY (Specific body part, extent of injuries):

MEDICAL TREATMENT: The injured person (or responsible party) should determine if medical treatment is necessary. It is their right to refuse medical care. In emergency situations, the immediate supervisor at the City and County facility shall request emergency medical assistance.

Medical Care Refused – Signature of injured person or responsible party:

FIRST AID ADMINISTERED AND BY WHOM:

TRANSPORTED BY:	DOCTOR/HOSPITAL:

NAME OF RELATIVE OR PERSON CONTACTED:

If injured party is a City and County employee, a *FIRST REPORT OF INJURY* form must be completed.

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SIGNATURE OF EMPLOYEE WITNESSING OR ATTENDING ACCIDENT/INJURY:	DATE:

(MORE)

SUPERVISOR'S INVESTIGATION REPORT (PAGE 2 OF 3)

To be completed if accident/injury involves City and County employee or City and County property. When an accident/injury occurs involving a City and County employee or City and County property, the immediate supervisor must interview the injured person (if injury occurred) and any witnesses, complete this form as thoroughly and accurately as possible and forward it to the Human Resources Department no later than one working day after the accident/injury occurs. It may be necessary to interview the person over the phone. This report is the City and County's primary investigation of a work-related accident/injury. It is extremely important that the facts of the accident/injury be recorded and the true causes of the accident/injury be identified. Attach additional sheet if more space is needed for explanations.

☐ EMPLOYEE INJURED – NAME/POSITION:

☐ **VE**HICLE/EQUIPMENT INVOLVED IN ACCIDENT – DESCRIPTION/CITY NUMBER/LICENSE PLATE:

☐ OTHER – BUILDING/PROPERTY/ADDRESS, ETC.

DEPARTMENT/DIVISION:		SUPERVISOR'S NAME/TITLE:	

DESCRIBE WHAT HAPPENED OR WHAT CAUSED YOU TO MAKE THIS INVESTIGATION – Get all the facts by studying the hazard or situation involved. Question by use of: When☐ Where☐ Who☐ What☐ How☐ Why☐ ATTACH ADDITIONAL SHEET IF MORE SPACE IS NEEDED

ADDITIONAL FACTORS INVOLVED – Did accident/injury result from failure to obey safety rule, failure to use safety equipment properly (seat belts, harnesses, oxygen masks, etc.) or any other such factors? Please describe and explain.

WHAT SHOULD BE DONE? (Determine which of the items require additional attention – EQUIPMENT [Select, Arrange, Use, and/or Maintain] – MATERIAL [Select, Place, Handle, and/or Process] PEOPLE [Select, Place, Train, and/or Lead]).

WHAT HAVE YOU DONE THUS FAR? (Action taken/follow up required?)

WHAT ADDITIONAL STEPS COULD BE TAKEN TO IMPROVE THE SAFETY OF YOUR OPERATIONS?

SUPERVISOR'S SIGNATURE _____ DATE _____ REVIEWED BY SUPPORT SERVICES:_____ DATE:_____

THIS SECTION FOR HUMAN RESOURCES DEPARTMENT USE*************************************

FORWARD TO ACCIDENT REVIEW COMMITTEE: ☐ YES ☐ NO – COMMENTS: _____

ACCIDENT REVIEW COMMITTEE NUMBER: _____ DATE OF ACCIDENT COMMITTEE REVIEW: _____

SENT TO SUPERVISOR FOR FURTHER ACTION: ☐ YES ☐ NO – COMMENTS: _____

(MORE)

WITNESS STATEMENT FORM (PAGE 3 OF 3)

This statement should be completed when there is a witness to an accident or injury. Please have each witness complete a separate statement.

Reporting Department/Division:

1. Date of Incident: Time of incident: ☐ AM ☐ PM
2. Information regarding injured party:
   Name: Department/Division (if employee):
3. Location of incident:
   Address:
4. Statement by witness:

Name of Witness:

Address:

Phone Number(s): (H)

Signature

Date