Hardeeville
SOUTH CAROLINA

INCIDENT REPORT

Safety - Near Miss ☐ Describe:

Staff Safety - Injury/Illness ☐ Death & Dismemberment ☐ Staff Endangerment ☐ Accident/Fall ☐

Customer Safety - Injury/Illness ☐ Accident/Fall ☑

Property Loss - Building ☐ Parks ☐ Vehicle ☐ Other Motorized ☐ Equipment ☐ Other Property Loss ☐ Stolen Property ☐

Fire and Emergency Response ☐

Police Response ☐

Public Works ☐

Vehicle - Vehicle Incident ☐ Vehicle Accident ☐

Endangerment - Irate/Threatening Person ☐ Shots Fired ☐ Terroristic Threatening ☐ Abduction ☐

Disaster - Hurricane ☐ Flooding ☐ Earthquake ☐ Ice Storm ☐ Citywide power outage ☐ Other ☐

Security Breach - Cyber Security ☐ Building Security ☐

***** FOR ALL INJURIES NOTIFY SAFETY & RISK MANGEMENT DIRECTOR IMMEDIATELY***

***** FOR ALL NON-INJURIES INCIDENTS NOTIFY DEPARTMENT HEAD/DIRECTOR IMMEDIATELY***

EMPLOYEE: Return this COMPLETED FORM to your SUPERVISOR immediately.

Date of Incident: (mm/dd/yr) _____ Time: (xx:xx) _____ ☐ am ☐ pm

Description of Incident/Complaint (Who, What, Where, How, Why, include sequence of events reason incident occurred).

1. NON-EMPLOYEE:

Name of Person Involved:

Home Address:

City: State: Zip code:

Home Phone Number: Cell Phone Number:

Email:

Age: DOB (mm/dd/yr):

Sex: M ☐ F ☐ SS#:

Exact Location of Incident:

Address:

City: State: Zip code:

County:

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2. EMPLOYEE: Involved ☐ yes ☐ no

Staff Name:

Home Address:

City: State: Zip code:

Home Phone Number: Cell Phone Number:

Staff Department:

Department Head/Director:

Employee Classification, (hourly or salary):

Employee Title: Employee Years of Service:

Was employee doing regular job duties: ☐ yes ☐ no

Observed only by employee: ☐ yes ☐ no

Protective Equipment being used: ☐ yes ☐ no
If not used, Why:

City vehicle involved: ☐ yes ☑ no If yes, please contact police for police report.

If yes: Make: Model:

Year: Color: VIN:

Wearing a seatbelt: ☐ yes ☐ no

3. INJURY:

Emergency Contact
Name:

Home Phone Number: Cell Phone Number:

Description of Incident/Complaint (Who, What, Where, How, Why, include sequence of events reason incident occurred).

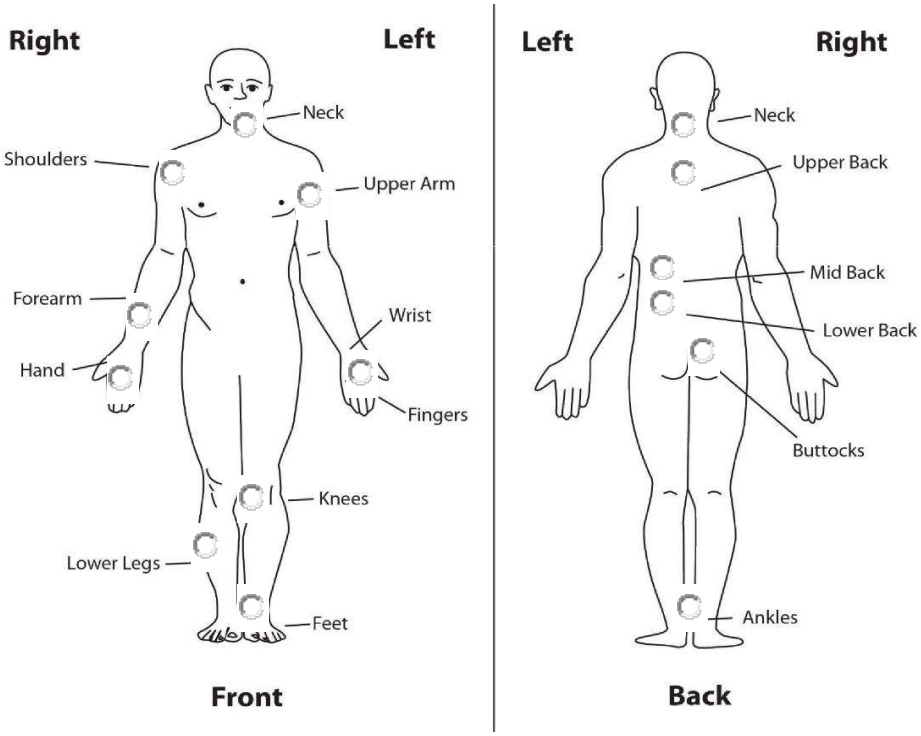
Need for medical assistance: ☑ yes ☐ no

Dial 911: ☑ yes ☐ no

Was an ambulance contacted: ☑ yes ☐ no

Description of injury/pain:

Location of any injury/pain: Please mark the following chart of where an injury or pain occurs. Just click on the button of the impacted area.



Transported to local medical center: ☐ yes ☐ no If yes, provide the name of the medical center.

A vehicle involved: ☐ yes ☑ no If yes, please contact police for police report.

Driver of the Car Name & Age:

How many people were in the car other than driver?

Name & Age: Name & Age:

Make: Model:

Year Color: VIN:

Insurance: _ yes _ no Insurance Carrier:

Insurance Carrier Address:

City: State: Zip code:

Insurance Carrier Telephone Number:

Insurance Policy Number:

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4. WITNESS:

Name of Person who witnessed:

Home Address:

City: State: Zip code:

Home Phone Number: Cell Phone Number:

Email:

Witness Statement:

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5. STAFF:

Actions Taken by Staff Members:

Signature of Person Involved with Incident: _____

Date: _____

Signature of Person Involved with Incident: _____

Date: _____

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6. INCIDENT/COMPLAINT REPORT

Incident Reported By: _____

Date: _____

Supervisor Notified: ☐ yes ☐ no Date: _____ Time: _____

Name of Supervisor: _____

Safety & Risk Management Director Notified: ☐ yes ☐ no

Date: _____ Time: _____

Signature and Title of Person Preparing Report: _____

_____

Date: _____

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7. SUPERVISOR COMMENTS:

_____

Supervisor Signature: _____

Date: _____

*Submit to Safety and Risk Management Director Immediately for Injury of an employee or non-employee

*Submit to Safety and Risk Management Director within 24 hours or next business day for non-injury

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***To Be Completed by Safety and Risk Management Director**

8. RISK MEASURES:

Corrective Action Taken/Follow-Up Measures put in place by Safety & Risk Management Director:

Safety & Risk Management Director Comments:

SCMIRT and SCMIT claim filed: ☐ yes ☐ no

Date: _____

Claim Number: _____

Worker Compensation claim filed: ☐ yes ☐ no

Date: _____

OHSA Contacted: ☐ yes ☐ no

Date: _____

9. SIGNATURES:

Safety & Risk Management Director Signature: _____

Date: _____

Claims Filer Signature: _____

Date: _____

City Manager Signature: _____

Date: _____

10. FOLLOW-UP:

Follow-up Review: (To be performed 3 months from the initial date filed. After the remedial action has been monitored and evaluated for effectiveness. If the incident has not been satisfactorily resolved, Safety and Risk Management Director should repeat the Initial Review Section, performing monthly reviews, and additional remedial action until satisfactory resolution is attained.)

Has the Incident recurred since the initial review?

- ☐ YES
- ☐ NO

Follow-up Reviewer's summary:

Signature: _____ Date: _____

Closure Date _____

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