CITY OF BALTIMORE

EMPLOYEE'S INCIDENT REPORT

IF FATALITY SHOW DATE ▶

☐ **NEW INJURY**

IF EMPLOYEE IS SENT TO CLINIC:
Complete this form before sending employee to Clinic. Keep copy for files. Send form with employee to Clinic.

IF EMPLOYEE IS SENT TO HOSPITAL:
Complete immediately after sending employee to the nearest medical facility for treatment.

CALL 1-877-607-8600 to report claim Date Called: Confirmation #:

☐ **RE-INJURY**

FOR A RE-INJURY CLAIM: FOLLOW CLINIC OR HOSPITAL INSTRUCTIONS ABOVE. Fax form to Sedgwick at 667-260-5086. DO NOT CALL IN CLAIM

1 Date this report

2 Date INCIDENT OCCURRED — Month | Day | Year | Time | Shift

EMPLOYEE SECTION

3 Employee's Name — Last | First | Middle Initial

4 Social Security Number

5 Job Title

6 Home Address

7 Phone - Home | Phone - Work

8 Agency

9 Division, Region, District, Unit, Etc.

10 Payroll Dept. Code

11 Payroll Location Code

12 Date of Birth | 13 Age | 14 Sex ☐ Male ☐ Female | 15 Date of Employment | Date assign, to pres. job

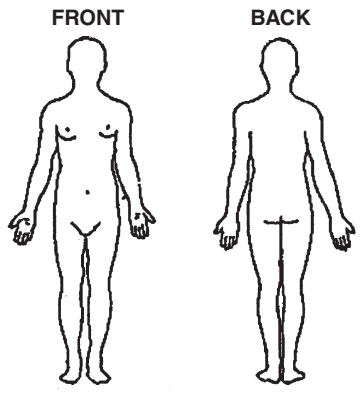
16 GROSS RATE OF PAY $ (HOUR, DAY, WEEK) PER

17 **DISPOSITION** ☐ CLINIC ☐ HOSPITAL Name-Hospital or Clinic

18 Specify exact address where incident occurred. Also specify exact location at this address.

19 Employee's description of how incident occurred. (Use additional signed sheets if necessary)

20 Circle Body Part Injured



Employee's Initials:

21 According to employee, what part(s) of his (her) body was injured.

22 Employee's Signature | Date | ☐ Check here if unable to sign

23 WHEN DID YOU FIRST LEARN OF INCIDENT? DATE | TIME ☐ AM ☐ PM

24 Is the employee's statement in accordance with Supervisor's knowledge of the facts ☐ YES ☐ NO
If no, explain details of incident in your words. (Use additional sheets if needed)

SUPERVISOR SECTION

25 Part of machine on which incident occurred

26 Was safety equipment provided? ☐ YES ☐ NO | Was it in use at time? ☐ YES ☐ NO

27 Was incident caused by injured's failure to observe safety rules? ☐ YES ☐ NO

28 Steps taken to prevent future similar injuries.

29 If injury due to vehicle accident:

MAKE/MODEL: SHOP/FLEET # COMPLAINT #

SEATBELT IN USE: ☐ YES ☐ NO PCD IN USE ☐ YES ☐ NO

30 WITNESSES

Name (Print)	CITY EMPL (✓)	ADDRESS	PHONE

31 Supervisor's Name and Title (Print) | Phone # | Signature | Date

GREY AREA - - POLICE AND FIRE DEPARTMENT USE ONLY

32 Signature - Investigating Officer | Date | Rank

33 Was injured employee acting in a higher grade at the time of this incident? ☐ YES ☐ NO

34 Signature -Commanding Officer or Battalion Chief | Date

28-1608-5149 REV. 3/09

1400-26-13

COPIES TO: 1.) MERCY (With Employee) 2.) SEDGWICK 3.) SAFETY (DOS) 4.) AGENCY