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

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. CITYVEHICLE ACCIDENT/PROPERTY/EQUIPMENT DAMAGE

Describe damage

Year ____ Make: ____ Model: ____ VIN: ____ Vehicle #: ____

Police called? Yes ☐ No ☐ 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:	
Was personal protective equipment in use? Yes No	Environmental: Yes No	Operator Error: Yes No
Was a seat belt worn? Yes No	Equipment: Yes No	Weather: Yes No