



EMPLOYEE'S REPORT OF ACCIDENT OR INJURY CITY OF LACONIA

To be completed by employee directly involved in personal injury or equipment accident.

PLEASE PRINT. THIS FORM WILL BE USED TO FILL OUT REQUIRED FORMS.
DO NOT LEAVE ANY INFORMATION BLANK.

Date of this report: _____			
Injury	Vehicle / Equipment	Exposure	

Name: _____ Department: _____

Job Title: _____ Date of hire: _____

Address: _____
Street/PO Box City Zip Code

Home telephone #: _____ Social security #: _____

Date of birth: _____

Date and time of incident: _____ A.M. / P.M. _____

Location of incident (exact): _____

If motor vehicle or equipment:

Vehicle plate #: _____ Vehicle ID #: _____

Was anyone injured? Yes No

If yes: Name: _____

Address: _____

Initial treatment:	None	On-site	Emergency Room
	Urgent Care _____		Other _____
Name of treating physician: _____			
Name of treating hospital: _____			
Will you lose time from work?	Yes	No	If yes, list dates: _____

(over)

Describe fully how the accident occurred - what you were doing; machine or equipment being used; where did it happen - on grounds, in building (identify); part(s) of body injured.

What action will you take to prevent this or a similar incident from occurring in the future:

Seek additional training

Be more aware

Caution other employees about this situation

Recommend an adjustment of the equipment involved

Other _____

Is this your first accident? Yes No

Witness(es): _____

Name(s) and Address(es): _____

Name of supervisor you notified: _____

Employee Signature: _____ Date: _____

PLEASE GIVE TO YOUR SUPERVISOR IMMEDIATELY; IF YOU CANNOT, PLEASE CONTACT THE PERSONNEL OFFICE AT 524-3877 EXT 227, EMAIL TO PBaumoel@laconianh.gov, OR FAX TO 524-1520.