CITY OF FAIRBANKS

EMPLOYEE INJURY REPORT FORM

This form is to be used to report ONLY employee injuries and may accompany any Workers Compensation and PROPERTY DAMAGE report forms.

EMPLOYEE SECTION

Employee Name: (last, first, MI)	Position Title:	Date & Time of Incident:
Department Name: CHOOSE ONE	Supervisor Incident Reported To:	Date & Time Incident Reported:
Employee Supervisor at time of Injury:	Exact Location of Incident:	Time Employee left work on day of Incident?
Shift:	Case/Run# (if applicable):	Was this a Motor Vehicle Accident? ☐ Y ☐ N
Restitution Requested & From Whom: ☐ Y ☐ N	Was First Aid Provided? ☐ Y ☐ N	Who Provided First Aid?
Did Employee seek Medical Attention: ☐ Y ☐ N	What Type of First Aid was Rendered?	

Name & Address where Medical Attention Obtained?	First 3 Days off, Employee Requests: ☐ Leave without pay. ☐ Annual Leave ☐ Sick Leave ☐ Comp Time	After the first 3 Days off, Employee Requests: ☐ Leave without pay. ☐ Annual Leave ☐ Sick Leave ☐ Workman's Comp & Leave WITHOUT pay ☐ Workman's Comp & Annual Leave ☐ Workman's Comp & Sick Leave ☐ Workman's Comp & Comp Time
If Medical Attention Sought, Discharge Slop & Return to Work Slip Must be Attached. ☐ Discharge Slip Attached ☐ Return to Work Slip Attached		
What type of Injury or Illness?	What body part was injured? (Indicate Right/Left if applicable)	List Witness Name & Phone Number

Employee Narrative of Incident:

EMPLOYEE SIGNATURE:

DIRECT SUPERVISOR SECTION

Confirm CAUSE of the Incident?

Were UNSAFE acts or conditions contributing factors to the Incident?

What specific Safeguards were used/not used?

Person with the Most Control of Object/Equipment/Substance?

What action has or will be taken to prevent Reoccurrence?

SUPERVISOR SIGNATURE:

ADMINISTRATION SECTION

LOSS SEVRITY POTENTIAL	PROBABLE REOCCURRENCE RATE	Routing		
		Date To	Department	Initials/Date
☐ MAJOR ☐ SERIOUS ☐ MINOR	☐ FREQUENT ☐ OCCASIONAL ☐ RARE		Department Head/Supervisor	
			Risk Management	
			Safety Committee Review	