INDIAN RIVER COUNTY INCIDENT REPORT

WORKERS' COMP ● LIABILITY ● PROPERTY LOSS ● AUTO ACCIDENTS/INCIDENTS

Complete Information For The Type Of Claim Reporting:

● Workers' Compensation: Complete Sections 1, 2, 6, 7, 8 ● General Liability: Complete Sections 1, 3, 6, 7, 8
● Property Loss or Vandalism: Complete Sections 1, 4, 6, 7, 8 ● Automobile Accident: Complete Sections 1, 5, 6, 7, 8

SECTION 1 – Employee Information

(Please Print, Except Signatures)

Name:	Division:	Department
Vehicle Number:	Year, Make, Model:	Vehicle Plate Number:
Type of Equipment (if not a vehicle)	Supervisor:	Date of Report

SECTION 2 – Workers' Compensation

(Use Additional Sheet if Necessary)

Employee's Description: Please provide as many details as possible.

Part of Body Injured:	Date of Injury:	Time of Injury:
Location Where Injury Occurred:		
What activity were you doing prior to accident:		
Employee's Written Description of Accident (Use Comment Section or Additional Sheet If Necessary):		

Supervisor's Description:

Supervisor's Written Description of Accident (Use Comment Section or Additional Sheet If Necessary):
What Did The Employee Do or Fail To Do That Caused Or Contributed To The Accident? Be Specific:
Describe Safety Appliances Used During The Accident Or Injury, Or The Lack of Safety Appliances (Include Failure Of Safety Appliances):
Describe Results of Action by Supervisory Staff Of Injured Employee Concerning Corrective Actions Or Prevention Of Future Accidents:
☐ I do not wish to seek medical treatment at this time.
I hereby state that the above information is correct and authorize my employer and my employer's workers' compensation carrier to have access to any and all medical records relevant to this claim.

Employee Signature		Supervisor Signature:	
Division Head Signature		Department Head Signature:	

SECTION 3 – General Liability or Incidents

Name of Claimant (Injured or Owner)		Phone Number (Include Best Time to Contact)	
Address of Claimant		Company Name (If Applicable)	
City, State, Zip		Claimants Employer	
Sex / Age: / Occupation		Claimants Employer Address & Phone	

Location of Accident, Loss or General Liability (Address)	Where Was Injured Taken:
Describe Injuries or Damage To Property:	Where and When Can Property Be Seen:
Date and Time of Loss, Accident or Injury:	Type of Property (Include Make, Model, Serial Number, Description and Date):

Instructions: Employee/Supervisor complete information / Route for Dept. Head Signatures
Copies: 1) Employee 2) Risk Mgmt.

SECTION 4 – Property Loss or Vandalism

(Please Print, Except Signatures)

Law Enforcement Report Number And Jurisdiction of Officer:	Date / Time of Loss:	Location
Written Description Of Loss: Include Kind of Equipment. Attach Asset Numbers, Model Numbers and Other Documents If Available: Use Comment Section or Additional Sheet If Necessary.		
Describe Security Devices Used To Protect Equipment Prior To Loss:		

SECTION 5 – Automobile Collision – Information on Non-County Driver involved in Collision

Name of Non-County Driver				Phone Number (Include Best Time to Contact)	
Address of Non-County Driver				Vehicle Owner's Name if different than driver:	
City, State, Zip				Insurance Co.	
Sex		Age:	Occupation	Policy Number:	
Location of Collision:		Where Can Property Be Seen:		Law Enforcement Report Number:	
Describe Damage (Include Description Of Collision In Comment Section):					
Make, Model, Year of Damaged Vehicle		License Plate and Vehicle Identification Number of Damaged Vehicle:			

SECTION 6 – Witnesses (Including Employees)

(Use Additional Sheet If Necessary)

Name	Address	Phone Number
1)		
2)		
3)		
4)		

SECTION 7 – Comments

(Use Additional Sheet If Necessary)

SECTION 8 – Signatures

Employee Signature		Supervisor or Investigator:	
Division Head Signature		Department Head Signature:	

Instructions: Employee/Supervisor complete information / Route to Dept. Head for Signatures
Copies: 1) Employee 2) Risk Mgmt.