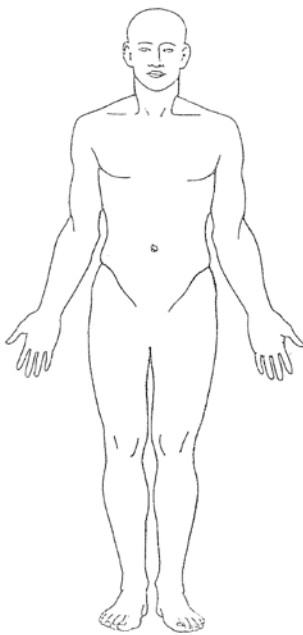
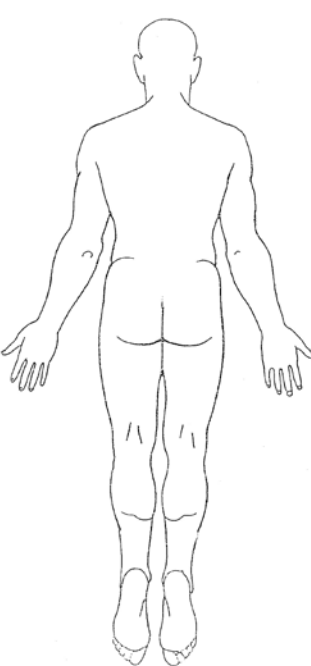


CITY OF DULUTH

INCIDENT REPORT

Supervisor and injured employee to complete within 24 hours of incident/injury.

Please print clearly and fax completed form to: 1-866-286-5258

Company Name: Duluth Police Dept.		Dept. / Div: Patrol		<input type="checkbox"/> Employee <input type="checkbox"/> Non-Employee	
Last name:		First:		Middle initial:	
Address:					
City:		State:		Zip code:	
Incident Date:		Time:		Phone:	
Left work:		Returned:		Lost time <input type="checkbox"/> Yes <input type="checkbox"/> No	
Explanation for Injury/Incident: _____					
Incident investigation conducted: <input type="checkbox"/> Yes <input type="checkbox"/> No					
Date supervisor notified:			Date report completed:		
Supervisor's name:					
Names / Phone #'s of witnesses: _____					
Was there a: Safety violation <input type="checkbox"/> Machine malfunction <input type="checkbox"/> Motor vehicle accident <input type="checkbox"/>					
Supervisor's comments: _____					
What actions have been taken to prevent recurrence? _____					
CAUSE <input type="checkbox"/> Slip and Fall <input type="checkbox"/> Struck by equipment <input type="checkbox"/> Lifting or moving <input type="checkbox"/> Caught (In, on or between) <input type="checkbox"/> Needle puncture <input type="checkbox"/> Object in eye (Right <input type="checkbox"/> Left <input type="checkbox"/> <input type="checkbox"/> Repetitive / Overuse <input type="checkbox"/> Other		MARK AREAS OF INJURY BELOW <div style="display: flex; justify-content: space-around;"> <div style="text-align: center;"> Front  </div> <div style="text-align: center;"> Back  </div> </div>			
TYPE OF INJURY <input type="checkbox"/> Scrape / Bruise <input type="checkbox"/> Sprain / Strain <input type="checkbox"/> Puncture wound <input type="checkbox"/> Cut / Laceration <input type="checkbox"/> Concussion <input type="checkbox"/> Bite <input type="checkbox"/> Chemical burn / Rash / Breathing difficulties <input type="checkbox"/> Other <input type="checkbox"/> No apparent injury					
Employee referred to: Clinic <input type="checkbox"/> Hospital ER <input type="checkbox"/> Refused to see MD <input type="checkbox"/>					
DR / Clinic			Phone Number:		
Supervisor's signature:			Date:		
Employee's signature:			Date:		

NOTE: Complete side 2 if Vehicle, Equipment, or Property Damage

INCIDENT LOCATION:			
POLICE CALLED? <input type="checkbox"/> Yes <input type="checkbox"/> No		Police Traffic Accident Report ICR#:	
City Vehicle, Property, or Equipment Involved	Description: _____ Vehicle #, Make, Model, Year: _____ Describe Damage: _____		
Non-City Vehicle, Property, or Equipment	Owner Name: _____ <input type="checkbox"/> Driver <input type="checkbox"/> Passenger <input type="checkbox"/> Other Owner Address/Phone #: _____ Vehicle License #: _____ Color: _____ Make/Model: _____ Year: _____ Describe Damage: _____		
<u>Weather Conditions</u>	<u>Roadway Conditions:</u>	<u>Light Conditions:</u>	<u>Other:</u>
<input type="checkbox"/> Clear <input type="checkbox"/> Wind <input type="checkbox"/> Rain <input type="checkbox"/> Cloudy <input type="checkbox"/> Fog <input type="checkbox"/> Sleet <input type="checkbox"/> Snow	<input type="checkbox"/> Dry <input type="checkbox"/> Mud <input type="checkbox"/> Wet <input type="checkbox"/> Paved <input type="checkbox"/> Snow <input type="checkbox"/> Unpaved <input type="checkbox"/> Ice	<input type="checkbox"/> Night <input type="checkbox"/> Day <input type="checkbox"/> Good <input type="checkbox"/> Poor	Approx. Temp: _____ Estimated Speed: _____ mph Vehicle: <input type="checkbox"/> Loaded <input type="checkbox"/> Empty What was load: _____ Drug and/or Alcohol Test? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A
MISCELLANEOUS COMMENTS: _____			

Sketch below how vehicle accident occurred (Give street names, direction of travel, locations of vehicles, objects and traffic control devices) ↑ North