

**COMMUNITY ACTION OF ORLEANS & GENESEE  
INCIDENT REPORT FORM  
INSTRUCTIONS**

**Any incident must be reported to your supervisor immediately.** Refer to Community Action's Safety Manual, Accident Reporting Section for a detailed definition of an incident / accident.

The injured person should complete the employee/volunteer/customer section, if possible. If not, the supervisor should complete the form. This is to be signed and dated by the person filling out the form. Give the completed form to your supervisor.

The supervisor then completes the supervisor section. Make sure all information is completed including the date and time you had knowledge of the incident. If you have questions or need assistance with completing the form, contact the Fiscal Office. Forward the original to the Program Director.

The Program Director reviews report, initialing the original and sending it to the Fiscal Department.

When completing the form please be sure to include any information you think will be helpful to the Fiscal Office or the insurance company, including any possible follow up. If necessary attach additional page.

If there are questions, call Diane Bechteler at the Fiscal Office at 585-589-5605.

**REMEMBER:**

**The incident report must be completed and submitted to the Fiscal Office within 48 hours of the date/time of the accident.**

# COMMUNITY ACTION OF ORLEANS & GENESEE INCIDENT REPORT

## EMPLOYEE SECTION – (or Volunteer / Customer)

- Name \_\_\_\_\_ Phone Number \_\_\_\_\_
- Home Address /City \_\_\_\_\_
- Date of Incident \_\_\_\_\_ Time: \_\_\_\_\_ Location: \_\_\_\_\_
- Were there any witnesses? Yes  No  If yes, who? \_\_\_\_\_
- Who did you notify? \_\_\_\_\_ When did you notify them? \_\_\_\_\_
- Was medical care offered? Yes  No   
If yes, type of care offered: Doctor  Hospital  Name of Provider \_\_\_\_\_
- Was 1<sup>st</sup> Aid Given? Yes  No  If yes, what type was given and by whom \_\_\_\_\_  
\_\_\_\_\_
- Describe the Incident ( Include the part of the body affected – Ex: - left shoulder, object involved – Ex.- child’s toy, and what you were doing – Ex. -walking downstairs) \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

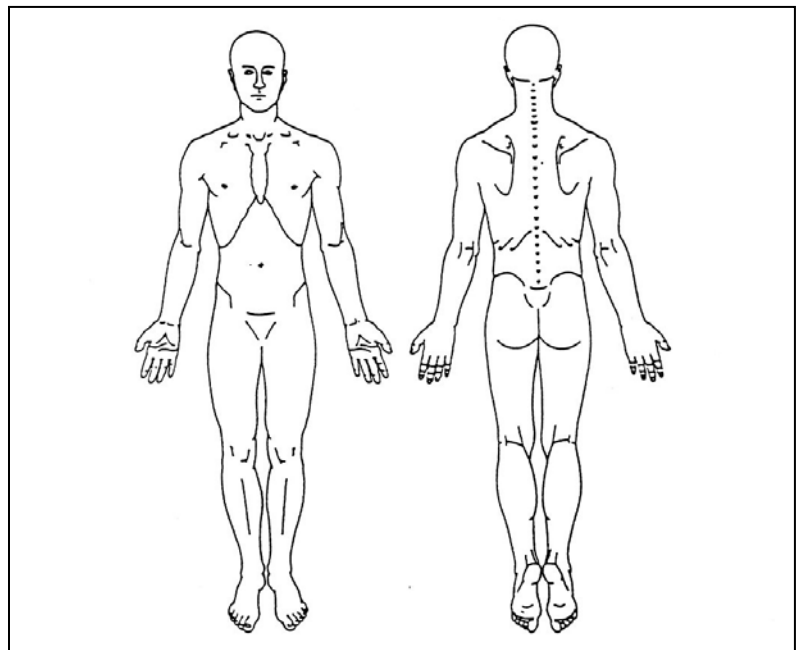
**ANATOMICAL LOCATION:**

- Abdomen
- Ankle:  Right  Left
- Upper Arm:  Right  Left
- Lower Arm:  Right  Left
- Back
- Chest
- Collarbone:  Right,  Left
- Ear:  Right  Left
- Elbow:  Right  Left
- Eye:  Right,  Left
- Face
- Finger (*specify*): \_\_\_\_\_
- Foot:  Right  Left
- Hand:  Right  Left
- Head
- Knee:  Right  Left
- Upper Leg:  Right  Left
- Lower Leg:  Right  Left
- Mouth
- Neck
- Nose
- Ribs
- Shoulder:  Right  Left
- Tooth
- Thumb:  Right  Left
- Other: \_\_\_\_\_

**PLEASE INDICATE LOCATION BY MARKING DIAGRAM BELOW:**

FRONT

BACK



\_\_\_\_\_  
Employee Signature

\_\_\_\_\_  
Date

# COMMUNITY ACTION OF ORLEANS & GENESEE INCIDENT REPORT

## SUPERVISOR SECTION

- Employee Name \_\_\_\_\_ Title: \_\_\_\_\_
- Date of incident: \_\_\_\_\_ Time of Incident: \_\_\_\_\_
- Location of incident: \_\_\_\_\_ Time and Date stopped work: \_\_\_\_\_
- Has employee returned to work? Yes  No  If yes, when: \_\_\_\_\_
- When were you notified? \_\_\_\_\_ By whom? \_\_\_\_\_
- Was medical care offered? Yes  No  Offered but refused  If yes, type offered: Doctor  Hospital
- Was 1<sup>st</sup> Aid given? Yes  No  If yes, what type was given? \_\_\_\_\_
- \_\_\_\_\_
- **CAUSE OF INJURY:** Animal  Bite  Chemical  Child  Collision  Cutting object  Door  Drugs   
Electrical  Fall  Falling object  Fight  Fire  Foreign object  Hot Liquid  Kick  Knife  Lifting  Poison   
Running into object  Thrown Object  Trip   
Other \_\_\_\_\_
- **NATURE OF INJURY:** Abrasion  Bite  Bruise  Burn  Concussion  Cut  Dislocation  Fracture   
Laceration  Poisoning  Pulled  Puncture  Scald  Scratch  Severed  Shock  Sprain
- Describe the Incident ( Include the part of the body affected – Ex: left shoulder, object involved – Ex: child’s toy, and what employee was doing – Ex. walking down stairs) \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
- What steps will be taken, if any, to prevent an occurrence in the future \_\_\_\_\_  
\_\_\_\_\_
- Was employee sent for a drug test? Yes  No  (Refer to Substance-Free Workplace & Testing Policy for requirements)
- Was there any disciplinary action taken? Yes  No  If yes, what? \_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
Supervisor's Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Director Initials

\_\_\_\_\_  
Date

**Original to Fiscal Office**

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# **WORKERS COMPENSATION INJURY**

(Take to Doctor or Hospital)

**EMPLOYER:**

Community Action of Orleans & Genesee  
409 East State Street  
Albion, NY 14411

**CONTACT:**

Diane Bechteler  
Payroll & Benefits Administrator  
585-589-5605

**REMIT BILL TO:**

Employer – Atten: Diane

11/10