

Incident Number \_\_\_\_\_

**CITY OF TOLEDO**  
**EMPLOYEE INJURY REPORT**  
(Section I to be completed by Employee)

NAME \_\_\_\_\_ SS# \_\_\_\_\_ DOB \_\_\_\_\_ MALE \_\_\_\_\_ FEMALE \_\_\_\_\_

DEPARTMENT/DIVISION \_\_\_\_\_ JOB CLASSIFICATION \_\_\_\_\_ WORK PHONE \_\_\_\_\_

TIME STARTED WORK \_\_\_\_\_ DATE OF INJURY \_\_\_\_\_ TIME \_\_\_\_\_ HOME PHONE \_\_\_\_\_

MEDICAL TREATMENT YES  NO  DOCTOR or HOSPITAL \_\_\_\_\_

LOCATION WHERE INJURY OCCURRED? \_\_\_\_\_

What were you doing when injury occurred? \_\_\_\_\_

How could this accident have been prevented? \_\_\_\_\_

Nature of Injury? \_\_\_\_\_

Witnesses:	Division	Phone	Division	Phone
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Have you ever injured this body part before? Yes  No  If yes when? \_\_\_\_\_

**Part of Body (please circle part of part affected)**

HEAD AND NECK	UPPER EXTREMITIES	BODY	LOWER EXTREMITIES
Ears	Arms (upper)	Abdomen	Ankle
Eyes	Elbow	Back	Feet
Face	Fingers and Thumb	Chest	Hips
Mouth, Teeth	Forearm	Groin	Knee
Neck	Hand	Lungs	Legs
Scalp	Shoulder	Other _____	Thigh
Skull	Wrist		Toes
Other _____	Other _____		Other

*The above represents true and correct statement of fact:* \_\_\_\_\_  
Employee' Signature \_\_\_\_\_ Date \_\_\_\_\_

**SUPERVISOR'S SECTION II**  
(To be completed by Supervisor)

Did you witness injury/accident? Yes  No

Summarize in detail your investigation of accident \_\_\_\_\_

Have you talked to witnesses? Yes  No  Was accident preventable? Yes  No  (If yes, complete below)

**CAUSES AND CORRECTIVE ACTION (Check & Recommend)**

Hazardous Conditions (circle)

- Congested area
- Defective tools, equipment or substance
- Hazardous layout
- Improper dress
- Improper illumination
- Improper ventilation
- Improper safety equipment
- Improperly or inadequately guarded
- Poor housekeeping
- Unsafe design or construction
- Improper work station/adjustment
- Other \_\_\_\_\_

Unsafe Act (circle)

- Failure to use safety equipment
- Making safety devices inoperative
- inoperative
- Operating at unsafe speed
- Improper training
- Improper lifting & carrying including insecure grip
- Using defective equipment, materials, tools, or vehicles
- Using equipment, tools, materials or vehicles unsafely
- Failure to adjust work station
- Others \_\_\_\_\_
- \_\_\_\_\_

Weather condition \_\_\_\_\_

Is Employee (circle one): 1. Permanent 2. Temporary 3. Seasonal 4. Intern 5. Contractual 6. Trainee

How could this accident have been prevented? \_\_\_\_\_

Supervisor's Signature \_\_\_\_\_ Date \_\_\_\_\_ Department Head/Director \_\_\_\_\_ Date \_\_\_\_\_

**REVIEWED BY SAFETY COMMITTEE** Date \_\_\_\_\_ Preventable  NonPreventable

Comments \_\_\_\_\_