CITY OF SEWARD NEBRASKA
537 MAIN ST
PO BOX 38
SEWARD, NE 68434-0038

PH: 402-643-2928
FAX: 402-643-6491

Accident Information

Date of Accident: _____

Date of Accident reported to Supervisor: _____

Number of hours worked per day: _____

Number of hours worked per week: _____

Time employee began work: _____

Time and Location of Accident: _____

Part of body affected (e.g. right forearm, lower back): _____

What are your injuries? (**IN DETAIL**):

_____

_____

_____

_____

Did you receive medical treatment: Yes ☐ No ☉ Not applicable ☐

Date you received medical treatment: _____

Did you miss any work: Yes ☐ No ☉

Wearing Personal Protective Equipment: Yes ☐ No ☉

Transported to Hospital: Yes ☐ No ☉

Describe IN DETAIL how the accident occurred and what you were doing:

_____

_____

_____

_____

_____

ACCIDENT INVESTIGATION REPORT TO BE COMPLETED BY SUPERVISOR WITH EMPLOYEE

Additional Information

CAUSAL FACTORS. Events and conditions that contributed to the accident.

_____

_____

_____

_____

_____

CORRECTIVE ACTIONS. Those that have been, or will be, taken to prevent recurrence.

_____

_____

_____

_____

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Name of Employee: _____

Home Address: _____

Home Phone: _____

Cell Phone: _____

Email Address: _____

Department: _____

Job Title: _____

Name and Address of Doctor: _____

ACCIDENT SEQUENCE: Describe in reverse order of occurrence events preceding the injury and accident. Starting with the injury and moving backward in time, reconstruct the sequence of events that led to the injury.

A. Injury Event: _____

B. Acccident Event: _____

C. Preceding Event #1: _____

D. Preceding Event #2, #3, etc: _____

WITNESSES (Names and Phone Numbers): _____

Employee Signature: _____ DATE: _____

DATE COMPLETED BY SUPERVISOR WITH EMPLOYEE: _____

PREPARED BY: _____ _____
Supervisor Signature Employee Signature

APPROVED BY: _____
Department Head Signature

DATE COMPLETED/SIGNED DOCUMENT SUBMITTED TO SAFETY COMMITTEE: _____

REVIEWED BY CITY ADMINISTRATOR _____
City Administrator Signature