

****MUST BE TURNED INTO HR DIRECTOR WITHIN 24 HOURS OF INCIDENT OCCURING****



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

PH: 402-643-2928

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. Accident 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

REVIEWED BY CITY ADMINISTRATOR _____
City Administrator Signature Date

REVIEWED BY HR DIRECTOR _____
HR Director Signature Date

SUBMITTED TO SAFETY COMMITTEE _____
Safety Committee Signature Date