



ACCIDENT/INCIDENT REPORT FORM

Date of incident: _____ Time: _____ AM/PM

Name of injured person: _____

Address: _____

Phone Number(s): _____

Date of birth: _____ Male _____ Female _____

Who was injured person? (Circle one) Passenger System Employee

Type of injury: _____

Details of incident: _____

Injury requires physician/hospital visit? Yes ___ No _____

Name of physician/hospital: _____

Address: _____

Physician/hospital phone number: _____

Signature of injured party

Date

*No medical attention was desired and/or required.

Signature of injured party

Date

Return this form to City Clerk's Office within 24 hours of incident.

MWCC - WORKERS' COMPENSATION - FIRST REPORT OF INJURY OR ILLNESS

EMPLOYER (NAME & ADDRESS INCL ZIP)		CARRIER/ADMINISTRATOR CLAIM NUMBER		REPORT PURPOSE CODE
		JURISDICTION	JURISDICTION CLAIM NUMBER	
		INSURED REPORT NUMBER		
SIC CODE	EMPLOYER FEIN	EMPLOYER'S LOCATION ADDRESS (IF DIFFERENT)		LOCATION # PHONE #

CARRIER/CLAIMS ADMINISTRATOR

CARRIER (NAME, ADDRESS & PHONE NO)		POLICY PERIOD TO	CLAIMS ADMINISTRATOR (NAME, ADDRESS & PHONE NO)
		<input type="checkbox"/> CHECK IF APPROPRIATE SELF INSURANCE	
CARRIER FEIN	POLICY/SELF-INSURED NUMBER		ADMINISTRATOR FEIN

AGENT NAME & CODE NUMBER

EMPLOYEE/WAGE

NAME (LAST, FIRST, MIDDLE)		DATE OF BIRTH	SOCIAL SECURITY NUMBER	DATE HIRED	STATE OF HIRE
ADDRESS (INCL ZIP)		SEX	MARITAL STATUS		OCCUPATION/JOB TITLE
		<input type="checkbox"/> MALE (M) <input type="checkbox"/> FEMALE (F) <input type="checkbox"/> UNKNOWN (U)	<input type="checkbox"/> UNMARRIED/SINGLE/DIVORCED (U) <input type="checkbox"/> MARRIED (M) <input type="checkbox"/> SEPARATED (S) <input type="checkbox"/> UNKNOWN (K)	EMPLOYMENT STATUS	
PHONE	# OF DEPENDENTS			NCCI CLASS CODE	
RATE	PER: <input type="checkbox"/> DAY <input type="checkbox"/> MONTH <input type="checkbox"/> OTHER: <input type="checkbox"/>	#DAYS WORKED WEEK	FULL PAY FOR DAY OF INJURY?		<input type="checkbox"/> YES <input type="checkbox"/> NO
			DID SALARY CONTINUE?		<input type="checkbox"/> YES <input type="checkbox"/> NO

OCCURRENCE/TREATMENT

TIME EMPLOYEE BEGAN WORK	<input type="checkbox"/> AM <input type="checkbox"/> PM	DATE OF INJURY/ILLNESS	TIME OF OCCURRENCE	<input type="checkbox"/> AM <input type="checkbox"/> PM	LAST WORK DATE	DATE EMPLOYER NOTIFIED	DATE DISABILITY BEGAN
CONTACT NAME/PHONE NUMBER			TYPE OF INJURY/ILLNESS		PART OF BODY AFFECTED		
DID INJURY/ILLNESS EXPOSURE OCCUR ON EMPLOYER'S PREMISES? <input type="checkbox"/> YES <input type="checkbox"/> NO			TYPE OF INJURY/ILLNESS CODE		PART OF BODY AFFECTED CODE		
COUNTY WHERE ACCIDENT OR ILLNESS EXPOSURE OCCURRED				ALL EQUIPMENT, MATERIALS, OR CHEMICALS EMPLOYEE WAS USING WHEN ACCIDENT OR ILLNESS EXPOSURE OCCURRED			
SPECIFIC ACTIVITY THE EMPLOYEE WAS ENGAGED IN WHEN ACCIDENT OR ILLNESS EXPOSURE OCCURRED				WORK PROCESS THE EMPLOYEE WAS ENGAGED IN WHEN ACCIDENT OR ILLNESS EXPOSURE OCCURRED			

HOW INJURY OR ILLNESS/ABNORMAL HEALTH CONDITION OCCURRED. DESCRIBE THE SEQUENCE OF EVENTS AND INCLUDE ANY OBJECTS OR SUBSTANCES THAT DIRECTLY INJURED THE EMPLOYEE OR MADE THE EMPLOYEE ILL

CAUSE OF INJURY CODE

DATE RETURN(ED) TO WORK	IF FATAL, GIVE DATE OF DEATH	WERE SAFEGUARDS OR SAFETY EQUIPMENT PROVIDED? WERE THEY USED?	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> YES <input type="checkbox"/> NO
PHYSICIAN/HEALTH CARE PROVIDER (NAME & ADDRESS)		HOSPITAL (NAME & ADDRESS)	INITIAL TREATMENT NO MEDICAL TREATMENT (0) <input type="checkbox"/> MINOR: BY EMPLOYER (1) <input type="checkbox"/> MINOR CLINIC/HOSP (2) <input type="checkbox"/> EMERGENCY CARE (3) <input type="checkbox"/> HOSPITALIZED > 24 HRS (4) <input type="checkbox"/> FUTURE MAJOR MEDICAL/ LOST TIME ANTICIPATED (5) <input type="checkbox"/>
WITNESSES (NAME & PHONE #)			
DATE ADMINISTRATOR NOTIFIED	DATE PREPARED	PREPARER'S NAME & TITLE	PHONE NUMBER