Accident/Incident Investigation Report
Public/Employee (*Circle One)*

(TO BE COMPLETED **IMMEDIATELY** AFTER ACCIDENT/INCIDENT, EVEN WHERE THERE IS NO INJURY-RETURN COPY TO HR@willmarmn.gov or deliver to HR in City Hall).

Date/Time Report______________________________ **Date of Injury** ____________
Time of Injury____________

Name ____

Department/Address______________________________ **Job Title**________________

Supervisor Name______________________________

Location of Accident/Incident____

Description of Injury____

Severity of Injury: (check appropriate box and give brief explanation)

___ **No Treatment Needed** ____
___ **First Aid Only** ____
___ **Doctor's Care** ____
___ **Restricted Work Activity**____
___ **Incident** ____
___ **Lost time** ____
___ **Near Miss** ____
Date of Medical Treatment____________________

EMPLOYEE/PATRON DESCRIPTION OF ACCIDENT

____
____
____

Witnesses Name____ **Statement Taken:** __Yes __No

Witnesses Name____ **Statement Taken:** __Yes __No

Photo's Taken ___Yes ___No **Date/Time**__________ **By Whom**________________________

Personal Protection Equipment used Yes___ **No** ___ **Type Used** ________________________

Other equipment involved, if yes, type of equipment ________________________________

Did employee return to work same day ___ **Yes** ___ **No** **Date Returned** ____________

Any restricted work activities: ____

What Steps have been taken to prevent reoccurrence of this incident? ________________________

____
____
____
____

Additional Comments ____

____

Signature of Supervisor ________________________________**Date** ____________

Signature of Employee ________________________________**Date** ____________

Facility Name: ______________________________

Safety Committee Comments:

____
____

____________________**Issue Resolved: Yes**____ **No**_____

Revisit issue ____