



MEMO REPORT OF INCIDENT/INJURY & SUPERVISOR'S INVESTIGATION REPORT

EMPLOYEE'S NAME: _____ EMPLOYEE ID #: _____

DEPARTMENT/DIVISION: _____ JOB TITLE: _____

DATE OF INCIDENT/INJURY: _____ TIME OF INCIDENT/INJURY? _____

THIS REPORT: INJURY INCIDENT FIRST AID ONLY NEAR MISS VEHICLE ACCIDENT
POLICE REPORT: YES ___ NO ___ POLICE REPORT #: _____

IMPORTANT: Any employee or volunteer that is involved/injured as a result of this incident/accident may be asked submit to Mandatory Drug & Alcohol test. The City has contracted with Drug Testing & More to be available 24/7/365. They can be reached at (956) 205-0103. Please contact Human Resources to determine if a Drug Test needs to be administered for this injury.

Was above employee administered a Post-Incident/Accident Drug & Alcohol Test: YES ___ NO ___
If NO, explain why: _____

DESCRIBE INCIDENT/INJURY: (Explain the incident/injury. Identify causes to incident. Answer: Who, What, When, Where, Why and How?)

IF INJURED, DESCRIBE THE INJURY AND INDICATE PART(S) OF BODY AFFECTED: (Body Diagram needs to be attached)

IF INJURED, WAS ANY TYPE OF TREATMENT ADMINISTERED ONSITE? YES ___ NO ___
If YES, indicate type (Ex: First Aid, Medication): _____

IF INJURED, WHEN WAS SUPERVISOR NOTIFIED OF INJURY? DATE: _____ TIME: _____ AM/PM

NAME AND ADDRESS IF WITNESS(ES): _____

Consider the objective when answering the following statements: Eliminate job hindrances, accidents and injuries.

WHAT CHANGES ARE RECOMMENDED TO PREVENT FUTURE OCCURRENCES OF SIMILAR INCIDENTS?

- PURCHASE NEW EQUIPMENT REDESIGN THE ACTIVITY/TASK TRAIN THE EMPLOYEE(S) ENFORCE POLICY/PROCEDURE
 DEVELOP NEW POLICY/PROCEDURE ADDITIONAL PERSONAL PROTECTIVE EQUIPMENT ROUTINELY INSPECT FOR HAZARD
 OTHER _____ ADDITIONAL COMMENTS: _____

EXPLAIN CORRECTIVE ACTION TAKEN AND HOW IT WILL IMPROVE OPERATIONS: (work order, training, disciplinary action, etc.)

FOLLOW-UP: WAS THE ACTION TAKEN EFFECTIVE?

HAS EMPLOYER'S FIRST REPORT OF ACCIDENT (DWC 1) BEEN FILED ON EMPLOYEE? YES NO NOT NECESSARY
I (Employee) Refuse Medical Treatment at this time: _____ Date: _____

Supervisor Name: _____ Title: _____

Supervisor Signature: _____ Date: _____

Reviewed by Risk Manager: _____ Date: _____

Note: Completed report is to be submitted to Human Resources - Risk Management. If employee is absent from work for more than one day (not counting the day of the injury; goes to a doctor or hospital; and/or receives medication, you must also complete the "Employer's First Report of Injury" (DWC-1) form and submit it promptly to Risk Management for processing. If a Memo Report of Injury has been filed regarding this injury and the employee later requires medical attention, promptly submit the DWC-1, with a notation that a Memo Report of Injury was previously submitted.