CITY OF NEW BERN

Employee Incident/Injury Report

EMPLOYEE INFORMATION (PLEASE PRINT)

Full Name:____

Job Title: ____

Department/Division: ____

Supervisor's Name: ______________________________ Phone Number: _________________________

INCIDENT/INJURY INFORMATION

Date of Incident: ___________________ Time:_______________ Employer's Premises? ❑ Yes ❑ No

Incident Address: ____

Witnesses: ____

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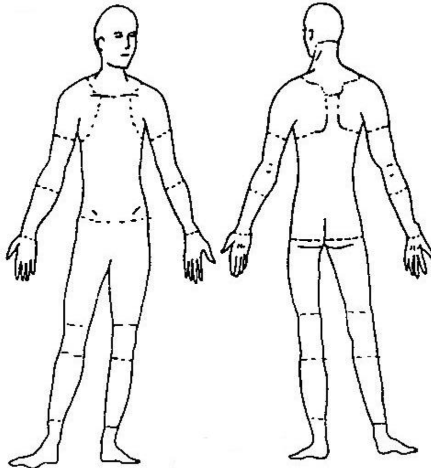
Describe the Incident

Brief Description of the incident:

Body Parts Affected

Part of body affected: (shade all that apply)	**Nature of injury:** (most serious one)	**This employee works:**
	Abrasion, scrapes Amputation Broken bone Bruise Burn (heat) Burn (chemical) Concussion (to the head) Crushing Injury Cut, laceration, puncture Hernia Illness Sprain, strain Damage to a body system: Other ___________	Regular full time Regular part time Seasonal Temporary **Months working in current position:** **Months performing this activity:**

Signature

Employee Signature:	**Date:**
Supervisor Signature	