Rev. 12/2024

TOMPKINS COUNTY ACCIDENT/INCIDENT REPORT

DIRECTIONS: Employee: Complete Section 1 and give to your Supervisor within 24 hours of incident.
Supervisor: Complete Section 2 and then forward this report within 48 hours:

County Administration: Send incident report, photos, any additional backup, and police report as soon as possible with 1 copy to Risk & Compliance Administrator and 1copy to Employee Health & Safety Coordinator.

Human Resources: If injury or illness to employee, **also** complete Employee Injury/Illness Report Form. Send copies of both reports to Human Resources.

Whole Health: If there is a bodily fluid exposure, **also** fax this report 274-6620 to Whole Health within 24 hours.

SECTION 1:

Department Name:	**Name of Employee(s) Completing this Report:**

..... Employee? Yes.....No..... Employee Hire Date: ……../……../.....
Name of Person(s) Injured or Property Owner Name

..... Employee ID# __ __ __ __
Home Address

....
Telephone Number Email Address

Date of Incident: / /	**Time of Incident: ◯ AM ◯ PM**

Location of Incident:

Officials called to the scene: ☐ Sheriff ☐ State Police ☐ Ithaca Police ☐ Fire Dept. ☐ Ambulance ☐ Other: ☐

Description of Injuries or Damaged Property:

STATEMENT: Describe who, what, when, where, why, and how. (Attach additional sheets as necessary, and/or sketch on reverse side)

Employee Injury:

Was there medical treatment rendered beyond first aid? ◯ Yes ◯ No

If so, where was this treatment rendered? .....

Was the employee hospitalized overnight? ◯ Yes ◯ No ◯ Unknown

Is this a recurrence of a previous injury or illness? ◯ Yes ◯ No If yes, please give details; treatment by what physicians?

.....

If employee injured, what time did employee start working today? .....

If employee injured, are you employed elsewhere? ◯ Yes ◯ No Where?.....

Employee Signature..... Date.....

DESCRIPTION OF CONDITIONS: List street name, weather conditions, ground conditions, etc.

CAUSE OF INCIDENT: List the factors that you believe contributed to this incident

PREVENTION: What actions, if any, can be taken now to prevent a recurrence?

Witness Name:..... Telephone.....

Witness Name:..... Telephone.....

Sketch, if necessary:

SECTION 2:

SUPERVISOR OR DEPARTMENT HEAD REVIEW, RECOMMENDATION AND FOLLOW-UP ON CORRECTIVE ACTION:

Person responsible for corrective action (if applicable):.....

Corrective Action Target Date:.....

Supervisor Signature:..... Print..... Date:.....

Captain Signature..... Print..... Date:.....

Department Head Signature:..... Print..... Date:.....

Date Incident Reported:..... Date Report Completed:.....

Note: If information is unknown at the date of this report, you are encouraged to complete an addendum or submit an additional report when additional details are known.