

**City of Rochester**  
**Joint Loss Management Committee**

**Accident/Incident Report Form**

(Joint Loss Management Committee form is to be completed for all employee accidents/incidents)

**Page 1 TO BE COMPLETED BY EMPLOYEE**

|   |  |
|---|--|
| Department:   | Division:  |
| Exact Location of accident/incident:      On City property? | Date of Occurrence:      Time:      Date Reported: |
| Specific task being performed at time of accident/incident: |  |

**Personal Injury or Illness**

**Property Damage**

|  |  |               |
|--|--|---------------|
| Occupation                               | Property damaged:  |               |
| What was injury or illness:              | Estimated costs:   | Actual costs: |
| What part of body was affected:          | Nature of damage:  |               |
| What equipment, tools involved:          | Object/Equipment/Substance/Inflicting injury or illness: |               |
| Materials, chemicals, etc being handled: | Unusual conditions:                                      |               |
| Unusual conditions:                      |  |               |

**DESCRIPTION**

|                                   |
|-----------------------------------|
| Fully describe accident/incident: |
|-----------------------------------|

**ACTION TAKEN**

Check all actions taken. If more than one, indicate which occurred 1st, 2nd, etc.2nd, etc.

|  |   |
|--|---|
| <input type="checkbox"/><br><input type="checkbox"/><br><input type="checkbox"/><br><input type="checkbox"/><br><input type="checkbox"/> | First Aid - administered by _____<br>Sent to Seacoast Redicare<br>Sent to Hospital<br>Sent Home<br>Continued Activity (no action taken) |
|--|---|

## ADDITIONAL INCIDENT INFORMATION

### Page 2 TO BE COMPLETED BY SUPERVISOR

Supervisor Comments (additional information on nature of incident detail, etc.)

#### Possible Causal Factors

- |   |   |
|---|---|
| <input type="checkbox"/> Housekeeping                               | <input type="checkbox"/> Tool/equipment use or selection    |
| <input type="checkbox"/> Work procedure, or lack of                 | <input type="checkbox"/> Level of support/assistance        |
| <input type="checkbox"/> Repetitive motion                          | <input type="checkbox"/> Awkward posture (s)                |
| <input type="checkbox"/> Tool/equipment condition                   | <input type="checkbox"/> Personal protective equipment use  |
| <input type="checkbox"/> Tool/equipment availability                | <input type="checkbox"/> Following of procedure/instruction |
| <input type="checkbox"/> Personal protective equipment availability | <input type="checkbox"/> Level of attention to task         |
| <input type="checkbox"/> Workstation /area setup                    | <input type="checkbox"/> Work pacing                        |
| <input type="checkbox"/> Flooring/ground                            | <input type="checkbox"/> Other                              |
| <input type="checkbox"/> Lighting                                   |   |
| <input type="checkbox"/> Ventilation                                |   |

Additional details on possible cause (s).

## PLANNED FOLLOW-UP ACTION

Supervisors description of planned action:

Supervisor Signature \_\_\_\_\_ Date \_\_\_\_\_

Dept. Head Signature \_\_\_\_\_ Date \_\_\_\_\_