Hanover County Employee Basic Injury Report

Section 1: Employee Information		
Last Name	**First Name**	**Employee Phone** (Cell and/or Work)
Employee Department		

Section 2: To be completed by Injured Employee or designee			
Date of Accident (MM/DD/YYYY)	**Time of Accident** (Military Time)	**Date Reported** (MM/DD/YYYY)	**Injury Type** O First Aid O Medical Treatment O Lost Time O Restricted Duty O Fatality
Location of Incident (Name of Facility)		**Describe Location of Incident** (i.e. stairs, loading dock, etc.)	
Facility Address		**City**	**State** / **Zip**
Time Shift Began (Military Time)	**Witnesses** (if any, list names of all below)		
If Fatality Event, provide date of fatality _____/_____/_____			
Was offsite medical care from Panel Physician provided? (If yes, provide facility & treating physician information below.) O Yes O No			
Facility/Physician Name			
Address	**City**	**State**	**Zip**
Hospital Visit? (If yes, provide address below.) ◯ Yes ◯ No	**Was Employee Hospitalized Overnight?** ◯ Yes ◯ No		
Hospital Name			
Address	**City**	**State**	**Zip**
Nature of Injury O Struck By O Struck Against O Fall (same level) O Fall (elevation) O Contact with stationary object O Contact with moving object O Contact with chemicals or hot surface	**Type of Injury** O Amputation (Full or Partial) O Fracture O Cut/Laceration O Crush O Puncture O Exposure to toxic chemicals or fumes O Burn (chemical or thermal) O Loss of an eye		
Body Part Injured (if multiple, list all body parts impacted)			
Employee Description of Incident (attach additional sheets as needed)			

Employee Name (print)	Employee Signature	Date

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Section 3: To be completed by Supervisor		
Supervisor Name	**Supervisor Phone** (Cell and/or Work)	**Supervisor Department**
LT/RD Case (if yes, indicate date RD began below)	◯ Yes ◯ No	
LT/RD Case Start Date _____/_____/_____		

Personal Protective Equipment	Required	Used
Gloves	◯ Yes ◯ No	◯ Yes ◯ No
Hard Hat	◯ Yes ◯ No	◯ Yes ◯ No
Eye Protection	◯ Yes ◯ No	◯ Yes ◯ No
Hearing Protection	◯ Yes ◯ No	◯ Yes ◯ No
Protective Footwear	◯ Yes ◯ No	◯ Yes ◯ No
Respiratory Protection	◯ Yes ◯ No	◯ Yes ◯ No
Other	◯ Yes ◯ No	◯ Yes ◯ No

Supervisor Comments (attach additional sheets as needed)

Root Cause(s) of Event (Preliminary)

Recommended Corrective Actions

Supervisor Name (Print)	Supervisor Signature	Date

Injury report should be submitted to Hanover County Safety & Risk Management as soon as possible, but no later than three (3) business days after the incident. Panel Physician selection information must be submitted along with incident report.

For additional guidance on completion of this form, please contact Hanover County Safety & Risk Management (804) 365-6227

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Employee Basic Injury Report (Witness Statement Form)

Instructions: Please utilize this form to capture witness statements. Once complete, this form along with any incident scene photos, supporting documentation describing the event or similar information should be attached. Utilize a separate witness statement form for each event witness

Witness Name:	
Date of Incident:	

Witness Statement (provide as much detail as possible. Attach additional sheets if necessary)