EMPLOYEE'S REPORT OF ACCIDENT OR INJURY
CITY OF LACONIA

To be completed by employee directly involved in personal injury or equipment accident.

PLEASE PRINT. THIS FORM WILL BE USED TO FILL OUT REQUIRED FORMS.
DO NOT LEAVE ANY INFORMATION BLANK.

Date of this report: _____

☐ Injury ☐ Vehicle / Equipment ☐ Exposure

Name: _____ Department: _____

Job Title: _____ Date of hire: _____

Address: _____
Street/PO Box City Zip Code

Home telephone #: _____ Social security #: _____

Date of birth: _____

Date and time of incident: _____ A.M. / P.M. _____

Location of incident (exact): _____

If motor vehicle or equipment:

Vehicle plate #: _____ Vehicle ID #: _____

Was anyone injured? ☐ Yes ☐ No

If yes: Name: _____

Address: _____

Initial treatment: ☐ None ☐ On-site ☐ Emergency Room

☐ Urgent Care _____ ☐ Other _____

Name of treating physician: _____

Name of treating hospital: _____

Will you lose time from work? ☐ Yes ☐ No If yes, list dates: _____

(over)

Describe fully how the accident occurred - what you were doing; machine or equipment being used; where did it happen - on grounds, in building (identify); part(s) of body injured.

What action will you take to prevent this or a similar incident from occurring in the future:

- ☐ Seek additional training
- ☐ Be more aware
- ☐ Caution other employees about this situation
- ☐ Recommend an adjustment of the equipment involved
- ☐ Other _____

_____

Is this your first accident? ☐ Yes ☐ No

Witness(es): _____

Name(s) and Address(es): _____

_____

Name of supervisor you notified: _____

Employee Signature: _____ Date: _____

PLEASE GIVE TO YOUR SUPERVISOR IMMEDIATELY; IF YOU CANNOT, PLEASE CONTACT THE HUMAN RESOURCE OFFICE AT 524-3877 EXT 152, or EMAIL TO lallen@laconianh.gov.

Revised August 2022