

TOWN OF MEREDITH

Incident Report Form

*Reports must be fully completed and submitted to the Town Manager's office within 24 hours of any incident.

TO BE COMPLETED BY MANAGER or SUPERVISOR of INJURED EMPLOYEE

Department:	Manager/Supervisor Completing Report:
WHO was injured:	Date of Report:
WHEN did the incident take place	<u> </u>
WHERE did the incident occur: (1	be as detailed as possible)
EQUIPMENT DAMAGE please de	escribe any damage to Town owned vehicles:
WHAT happened: (Clearly describ	be what happened including events leading up to the incident)
WHY did this happened: (i.e. was supplied to the individual?)	person not wearing supplied PPE? Was the particular PPE not

Personal Injury - Was an injury sustained: YES NO (skip this section)						
Part of body affected:		Nature of injury:				
Did injured leave work:	Time:		Date:			
Did injured go to doctor:		Was injured transported by ambulance? Where to?				
Name of Physician		Did injured return to work:				
Was emergency care needed:		Was a police report filed:				
Provide details:						
Corrective Actions:: (To be		nager)				
Was this incident preventable? How?	YES NO					
What will be done to prevent this	incident from happ	ening again?				
Signatures						
Signatures						

Are there any supplemental forms to this report? (i.e. witness statements, slip/trip/fall form/ doctors notes)

Slips, Trips, & Falls - Supplemental Incident Form				
What was the condition of the walking surface? (i.e. damaged, worn, wet, icy, cluttered)				
Was the hazardous condition reported prior to the incident?				
How long had the condition existed?				
Was the hazardous condition corrected? How? When?				
Was the lighting adequate?				
Was the employee wearing appropriate footwear?				
Was the employee carrying/pulling anything?				
Have similar incidents occurred at this location prior to this accident?				
Employee Statement Name:				
Employee signature certifying truthfulness of their statement:				
Employee signature certarying truthrumess of their statement.				
Witness Statement Name:				
With and signature contifuing to the following of their statements				
Witness signature certifying truthfulness of their statement:				

Safety Committee Review						
Did the manager provide a good de	escription of the in	cident and the con	tributing factors?			
Are the corrective actions logical to correct the incident from reoccurring?						
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Recommendation from the Safety	Committee:					
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	PROCESSING I		RESOURCES DEPARTMENT			
First Name		e Initial	Last Name			
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Date of Birth	Social Security N		Number			
Addragg						
Address:						
Telephone Number:	Wages Per Hour		Date Employment Began:			