

INITIAL INCIDENT REPORT – BONNER COUNTY



THIS FORM MUST BE COMPLETED IN ENTIRETY-THIS FORM IS REQUIRED FOR ALL INCIDENTS AND INJURIES.

Personal Information

Employee Name: _____ Position/ Department: _____

Name of other party: _____ Phone: _____

Other party address: _____ Contact info for other party: _____

Employee witness to incident? Yes No Was s/he on the job at the time of the accident? Yes No

Claim Information Internal Claim ID#: _____

Date of Occurrence: _____ **Time of Occurrence:** _____ **Shift start time:** _____

Location: _____

Incident Description: _____

Vehicle/Equipment Involved? Yes No *(If this is an auto accident also use Bonner County Auto Accident Report.)*

Describe damage: _____

Personal Injury

Was the other party injured? Yes No Nature of injury: _____

(For employee injuries also have witnesses complete this Initial Incident Report Form. Use back of form for more space if needed. You are required to go to one of our designated providers (North Idaho Medical Village Suite 100 or Newport Health Center) for medical treatment unless it is an emergency or after hours.)

Investigation

Investigated? Yes No If yes, agency? _____ Case Number _____ Charges _____

Witness Information (Name, address, phone): _____

EMPLOYEE SIGNATURE: _____ **DATE:** _____ **Preventable?** _____

IMMEDIATE SUPERVISOR SIGNATURE: _____ **DATE:** _____ **Preventable?** _____

DIRECTOR/ELECTED SIGNATURE: _____ **DATE:** _____ **Preventable?** _____

RISK MANAGEMENT: _____ **DATE:** _____ **Preventable?** _____

Corrective action taken to prevent reoccurrence: _____

ALL INCIDENTS MUST BE REPORTED TO RISK IMMEDIATELY: riskmanagement@bonnercountvid.gov or FAX: 208-265-1457