INITIAL INCIDENT REPORT – BONNER COUNTY

Personal Information

Employee Name:____________________________________Position/ Department: ______________________

Name of other party (if applicable):____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

Date of Occurrence: ____________ Time of Occurrence:_______________ Shift start time:_______________

Location: ____

Incident Description: ____ __________________________________

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Claim number (from Risk)____

Vehicle/Equipment Involved? ☐ Yes ☐ No Bonner County owned vehicle? ☐ Yes ☐ No

Describe damage: ____

Year:____________ Make:____________________ Model:______________ Last 4 of VIN:____________________

Personal Injury

Was a party injured? Yes ☐ No ☐ Nature of injury: ____

(For employee work related please contact SIFCare at ***866.453.5216*** *to set up a workers compensation claim)*

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?__________

ALL INCIDENTS MUST BE REPORTED TO RISK IMMEDIATELY: riskmgtgroup@bonnercountyid.gov **or FAX: 208-265-1457**

Revised: 4/20/26