

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: _____

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: Risk@bonnercountvid.gov or FAX: 208-265-1457