**INITIAL INCIDENT REPORT – BONNER COUNTY**

# 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

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

Location:

Incident Description: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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 **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. Risk will complete First Report of Injury. Please go to one of our designated providers (Woodlands Family Medicine or Newport Health Center) for medical treatment.)***

# 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:** riskmanagement@bonnercountyid.gov **or FAX: 208-265-1457**

Revised: 2018 09 05