COUNTY OF EL PASO

Investigation Report of Occupational Injury/Illness

This report is for internal use only and should be used for reporting an injury or illness, the witnessing of an injury, reporting unsafe conditions, or any other condition that should be reported to the Risk Management Section. This report should be completed and faxed to 546-8126 by the Supervisor within 48 hours of the injury or incident. The supervisor will maintain a copy and forward the original to the Risk Management Section.

EMPLOYEE'S REPORT OF INJURY *(Part I)*

1. Employee's Name: (Last, First, Middle Initial)	2. Dept. & Occupation:	3. Date & Time of Injury:
4. Employee's Home Address:	5. Employees Home/Cell #:	6. Social Security Number:
7. Supervisor Name & Date Reported to Supervisor:	8. Absence due to Injury: Yes ☐ No ☐	9. Date Loss Time Began
10. Accident Location:	11. Today's Date:	

Type of Incident: Injury Occupational Illness Non-injury Incident Exposure Incident

12. **Briefly describe what you were doing at the time of the injury and the injury being claimed.**

13. **Briefly describe where the incident occurred including any surrounding, environmental concerns or physical concerns that might have been contributing factors.**

14. **How should the conditions or physical surroundings be changed to prevent similar incidents?**

15. **Were there any witnesses? If yes, please list. (Name & contact info)**

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I hereby certify that the information above and on the second part of this form is true and correct to the best of my knowledge. I understand that any falsification of the information regarding an on-the-job injury or illness may result in disciplinary action and/or prosecution under the appropriate State Criminal Statues.

_______________________________ _______________________________

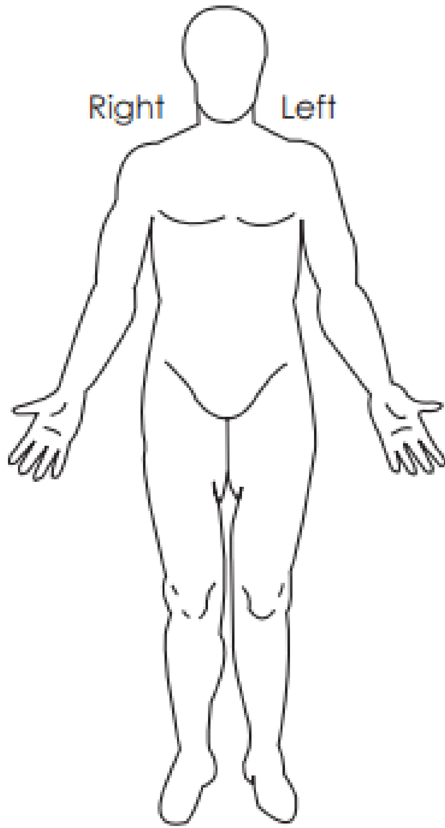
Employee's Signature **Date**

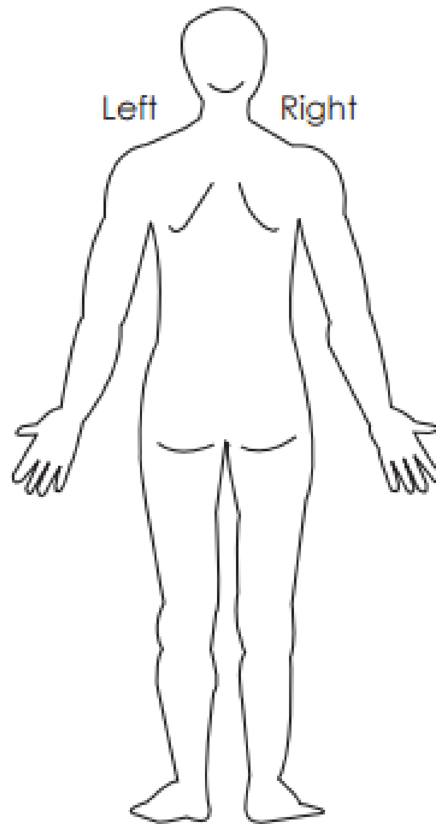
(Part II)

Instructions: Please circle the part(s) of your body where you are experiencing pain due to this injury.

Name: ____

SSN: __________________________ **Date of Injury:** __________________________





______________________________ Employee's Signature

______________________________ Date

Employee does not feel medical treatment is necessary at this time

If the employee does not feel medical treatment is necessary at the time of completing the form but later elects to seek medical treatment, the employee must contact the Risk Management Section immediately at 546-2218 ext. 4286

______________________________ Employee's Signature

______________________________ Date

Revised 11/01/2017

SUPERVISOR'S REPORT OF INJURY OR OCCUPATIONAL ILLNESS
(Part III)

Department:	Date of Incident:
Name of Employee:	Social Security Number:
Reported to:	Date & Time Reported:

Type of Incident: Injury Occupational Illness Non-injury Incident Exposure Incident

Location of Incident: ____________________

Time Occurred: ________ AM or PM **Day of the Week:** ____________________

Worked Remainder of Shift: Yes or No **Time Shift Started:** ____________________

Employee was: Alone or With Co-Worker **Who:** ____________________

Supervision at Time of Incident: Directly Supervised Indirectly Supervised Not Supervised

Specific Activity When Incident Occurred: ____________________

Was this a Normal Duty: Yes or No

Describe What Happened:

How should the conditions or physical surroundings be changed to prevent similar incidents:

____

Severity: First Aid Only Medical Treatment ____________________
Refused Medical Treatment Fatality

No Lost Time **Losing Time Now** **Date Lost time began:** ____________________

Property Damage: Yes or No **Type:** ____________________

Vehicle Involved: Yes or No **Description:** ____________________

Seat Belts Worn: Yes or No

Was the employee violating County safety policies or other known safety policies, procedures?

I hereby certify that the information above and on the second part of this form is true and correct to the best of my knowledge. I understand that any falsification of the information regarding an on-the-job injury or illness may result in disciplinary action and/or prosecution under the appropriate State Criminal Statues.

____________________	____________________	____________________
Supervisor's Signature	**Title**	**Date**

Revised 11/01/2017