

HYDE COUNTY ACCIDENT REPORT

Name of Employee: _____

Employee's Address: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Birth date: _____ Date Hired: _____

Department: _____ Date and Time of Injury: _____

Have you ever claimed Workers Comp before? Yes/No

Have similar accidents occurred to you in the past? _____

On the Job? Yes/ No Body Part Injured: _____

How long have you been employed with Hyde County? _____

Does your Supervisor know of this injury? Yes/ No

Who was the accident first reported to? _____

Location of where the injury happened: _____

Was anyone notified? Police/EMS/Others _____

Was there a witness to the injury? Yes/No

Eyewitness Name, Address and Phone Numbers:

Was the person injured acting in the normal line of duty? Yes/ No

Was equipment involved in or cause the accident? Yes/No

What type of equipment/object or substance directly harmed the employee:

What was the person doing immediately prior to the accident? _____

What is the normal occupation and activity of the person that was injured? _____

Did the person continue/cease working? Yes/No Was the person hospitalized? Yes/No

Is there time lost beyond the date that the injury happened? Yes/No How long? _____

Was there any treatment given at the time of the accident? Yes/No What kind? _____

Did the person--go to the hospital/doctor's office/home or refuse medical treatment/transportation

Name of the hospital: _____

Diagnosis/Treatment of injury if known: _____

Date disability began: _____

Is there a fatal injury involved? Yes/No

Employee's Verification of Report and Consent for Release of Medical Information

I hereby verify that all of the information contained in this report and my written statement of this occupational injury/accident is accurate to the best of my recollection of the circumstances leading up to and including the incident which caused the injury. I also acknowledge and provide my consent to the **County of Hyde Workers Compensation Services and/or their agent to obtain medical records and reports relating to this injury.**

Print Name _____ Occupation _____

Signature _____ Date Report Completed _____

Print Name of Witness _____ Date Signed _____

Signature of Witness _____

General Instructions

Please answer every question on the accident report.

The County's Workers Comp-Dr. Charles Boyette **MUST** be utilized for **ALL** accidents. His office number is **943-6144**.

Submit the original report and a detailed, written explanation of the accident to your supervisor immediately. You must also get written statements from any eyewitnesses and include these.

Your supervisor must immediately forward to the Finance Office and Emergency Management.

The original of this report is to be submitted to the Finance Office to Corrine Gibbs who is the Assistant Finance Officer.

This report is to be submitted within 24 hours of the accident to all parties. If an accident occurs outside of normal working hours and involves medical treatment to any party, you must contact Emergency Management by way of the 911 center.

The injured employee is responsible for notifying the supervisor/department head immediately after the accident occurs.

The injured employee's supervisor/department head is responsible for notifying the Finance Office of the exact dates the employee is to be absent from work due to the accident or injury.

Any pictures that were taken need to be included. Originals only. For any significant event, please notify Emergency Management to come to the location.

Was there a police report? If so, a copy shall be included.

ON A SEPARATE PIECE OF PAPER PLEASE DESCRIBE WHAT HAPPENED.

EACH EYEWITNESS WILL NEED TO SUBMIT A WRITTEN STATEMENT OF WHAT THEY SAW AT THE ACCIDENT.