MORROW COUNTY EMS
INCIDENT REPORT

1. If an employee is injured on the job, that **Employee** and their **Supervisor** must complete all applicable sections of this form, and forward it to the Chief.

2. If an employee's on-the-job actions result in an injury to the employee or another person and either one of the following conditions applies, the **employee must be drug and alcohol tested immediately**.
Condition 1. Medical attention is immediately sought away from the scene; and/or
Condition 2. A vehicle or equipment is towed away from the scene or rendered inoperable.

3. Call your supervisor or the chief if you have any questions.

PART A:
EMPLOYEE MUST COMPLETE THIS SECTION AND FORWARD TO SUPERVISOR.

Name_____Signature _____

Incident Location_____Incident Date_____ Incident Time_____

Was this incident an: **INJURY, PROPERTY DAMAGE, OTHER (**Circle one and describe below)

Description should include information such as: sprained ankle, cut, broken bone, damaged vehicle or utility, etc. Provide specific details about what happened, how it happened, and/or events that led up to the incident. (Use another sheet if necessary)

_____
_____
_____
_____
_____
_____
_____

Was a law enforcement report taken? **Yes No**
By whom? **Sheriff** / **State Hwy Patrol / Other**_____ (circle one)
Report # _____(please send a copy of the law enforcement report as soon as possible)

INJURY INFORMATION
Did you or anyone else get medical attention at or away from the scene? **Yes / No / Unknown**
Will you, or did you, miss any time from your normal work duties, **not** including the day that the injury occurred? **YES NO**
Who was treated? What treatment was given? What was the name of the Doctor? (If known)

_____
_____
_____

VEHICLE INFORMATION Was a **COUNTY** vehicle involved (circle one) **YES** or **NO**
County Make of Vehicle_____Model_____Vehicle Year_____
WAS ANOTHER VEHICLE INVOLVED? Yes or **No** (if yes complete the information below)
Driver's name: _____ Phone number: _____
License plate number: _____ Insurance company_____
Policy number_____

PART B: WITNESS STATEMENT ABOUT INCIDENT (to be completed by witness):
Witness Name _____ Signature _____
Ph # _____Date_____
Witness Statement (use another sheet if needed)_____
_____
_____
_____
_____

Witness Name_____ Signature_____
Ph #_____Date_____
Witness Statement (use another sheet if needed)_____
_____
_____
_____
_____

PART C: SUPERVISOR MUST COMPLETE AND FORWARD TO THE EMS MANAGER
Name_____Signature_____
Date _____ Time _____Your phone #: _____

Supervisor Statement (use another sheet if needed)
_____
_____
_____
_____
_____
_____

Did this employee receive an alcohol or drug test for this incident? **Yes No** (if yes complete next section below)
Hospital name_____ Attending Physician_____
Date_____ Time_____

Chief's review, signature_____ Date_____