

## CITY OF RACINE EMPLOYEE'S FIRST REPORT OF INCIDENT

Employee Name (First, Middle, Last)					Sex	M F	Employee Home Telephone No.	
Employee Home Street Address			City	State	Zip Code		Occupation	
Birth Date		Date of Hire			County and State where accident or exposure occurred			
Injury Date Mo/Day/Yr	Time of Injury	Last Day Worked	Date Employer Notified Mo/Day/Yr		Shift Working at time of incident (i.e., 7:00 – 4:00)		Did you leave work? Yes No Estimated Date of Return:	
Location where injury occurred-be as specific as possible								
Were you or do you anticipate being treated by a medical professional for this injury or illness? <input type="checkbox"/> Yes <input type="checkbox"/> No <b>Name and address of medical professional and/or Hospital:</b>								
Were you hospitalized for this injury or illness? <input type="checkbox"/> Yes <input type="checkbox"/> No								
<b>Area Injured</b>								
1 <input type="checkbox"/> Head		9 <input type="checkbox"/> Finger: Specify:			15 <input type="checkbox"/> Knee <input type="checkbox"/> L <input type="checkbox"/> R			
2 <input type="checkbox"/> Eye <input type="checkbox"/> L <input type="checkbox"/> R		10 <input type="checkbox"/> Chest			16 <input type="checkbox"/> Ankle <input type="checkbox"/> L <input type="checkbox"/> R			
3 <input type="checkbox"/> Back		11 <input type="checkbox"/> Abdomen			17 <input type="checkbox"/> Foot <input type="checkbox"/> L <input type="checkbox"/> R			
4 <input type="checkbox"/> Shoulder <input type="checkbox"/> L <input type="checkbox"/> R		12 <input type="checkbox"/> Pelvis			18 <input type="checkbox"/> Toe: Specify:			
5 <input type="checkbox"/> Arm		13 <input type="checkbox"/> Hip			19 <input type="checkbox"/> Other:			
6 <input type="checkbox"/> Elbow		14 <input type="checkbox"/> Leg <input type="checkbox"/> L <input type="checkbox"/> R						
7 <input type="checkbox"/> Wrist								
8 <input type="checkbox"/> Hand								
<b>Type of Injury</b>								
1 <input type="checkbox"/> Abrasion		7 <input type="checkbox"/> Cut/Laceration			13 <input type="checkbox"/> Puncture			
2 <input type="checkbox"/> Amputation		8 <input type="checkbox"/> Foreign Body			14 <input type="checkbox"/> Rash/Dermatitis			
3 <input type="checkbox"/> Bite		9 <input type="checkbox"/> Fracture			15 <input type="checkbox"/> Respiratory			
4 <input type="checkbox"/> Bruise		10 <input type="checkbox"/> Hearing Impaired			16 <input type="checkbox"/> Strain/Sprain			
5 <input type="checkbox"/> Burn		11 <input type="checkbox"/> Infection			17 <input type="checkbox"/> Exposure			
6 <input type="checkbox"/> Concussion		12 <input type="checkbox"/> Pain			18 <input type="checkbox"/> Other:			
Injury Description: Describe your activities when injury or illness occurred and what tools, machinery, objects, chemicals, etc. were involved. (Use additional page if necessary)								
What happened to cause this injury or illness? (Describe how the injury occurred. Use additional page if necessary)								
Describe your injury or illness. (State the part of body affected and how it was affected. Use additional page if necessary)								
Additional Page(s) attached. <input type="checkbox"/>								
Witness (es)-Names of all employees and non-employees who witnessed your injury or illness. (Use additional page if necessary)								
Employee Signature:						Date signed:		
Supervisor Signature:						Date signed:		
Report Submitted By:			Work Phone		Position:		Date Submitted:	

Fax This Form to Human Resources at 262-636-9585