Glynn County Board of Commissioners
ACCIDENT/INCIDENT INVESTIGATION REPORT

1. Complete applicable sections: A (Employee involved), B (County vehicle involved), C (Public involved), and D (ALL accidents/incidents), immediately following the accident/incident.
2. **Attach completed Workers Compensation First Report of Injury (WC-1) for all injured employees.**
3. Send completed reports to the Human Resource Department. Attach Police Report for all accidents/incidents involving vehicles, if applicable. Glynn County Board of Commissioners, Human Resources 1725 Reynolds Street, Suite 102 Brunswick, GA 31520 (912-554-7170).

Accident or Incident Date: ______________________________________ Time: _________________________

Accident/Incident Location: ____

Department: ____ Division: ______________________

A. Complete for Accidents/Incidents involving employees:

Name	Phone #	Employee #	Position	Department

Did the accident/incident result in injury (ies) to employee(s)? ______Yes ______No
Attach Workers' Compensation First Report of Injury (WC-1) for each injured employee.

Was medical treatment required or requested? ______Yes ______No ______Unknown

Was the employee seen by a Workers Compensation Physician? ______Yes ______No

Treatment provided by: ____

Date of Physicians Visit: ___________________ Is Employee able or released to duty? ______Yes ______No

If not released to return, expected date of return: ____________________________________

Was post-accident/incident drug screen performed? ______Yes ______No ______Unknown

B. Complete for County vehicles involved:

Name of Driver: ____Department: _______________________

EMP #:________________ Vehicle Make: __________________ Model: ________________ Year: ____________

Mileage: __________________________________ Unit#: ________________ Last 4 VIN #:_________________

Program: ________________________________ Reported By: ____

Supervisor: ____ Date Supervisor Notified________________________

Motor Vehicle Accident Report # (if another vehicle involved):____

C. Complete for accidents/incidents involving persons other than employees:

Name:	Address:	Telephone Number:

If the accident/incident resulted in injury to persons other than employees
Who was injured? ____

Was the injured person a minor? ______Yes ______No

If yes, was a Guardian present or notified? ______________ Relationship to minor: ______________________

Guardian Name/Address/Phone Number: ____

____

Was medical treatment required? ______Yes ______No ______Unknown

Treatment provided by: ____

D. Complete the following for ALL accidents/incidents:

Name/Address/Phone Number of witnesses:

Describe what happened in DETAIL at the time of injury, what was the employee doing (Attach police report if accident involved vehicle(s))

Was safety equipment, additional personnel, etc. used to reduce the chances of injury? ______Yes ______No
Explain:

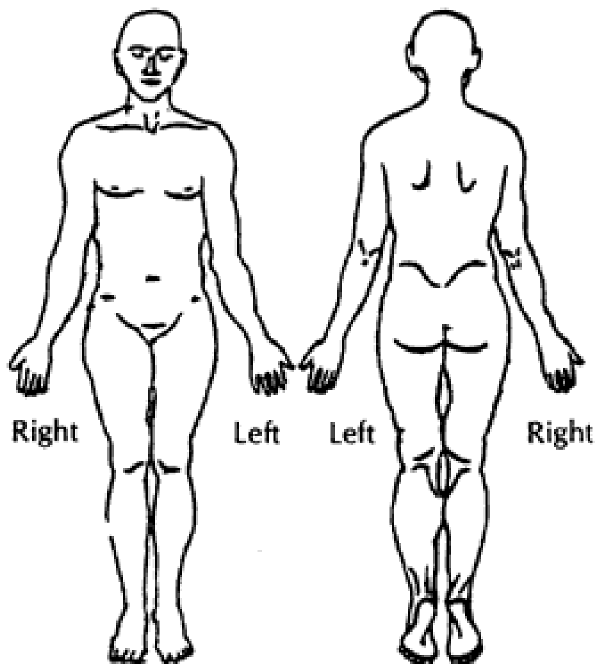
Why did this happen? Explain in DETAIL how the injury occurred? What contributed to the injury (Human error, incorrect use of equipment, lack of training)?

In your opinion, what can be done to prevent similar accidents in the future?

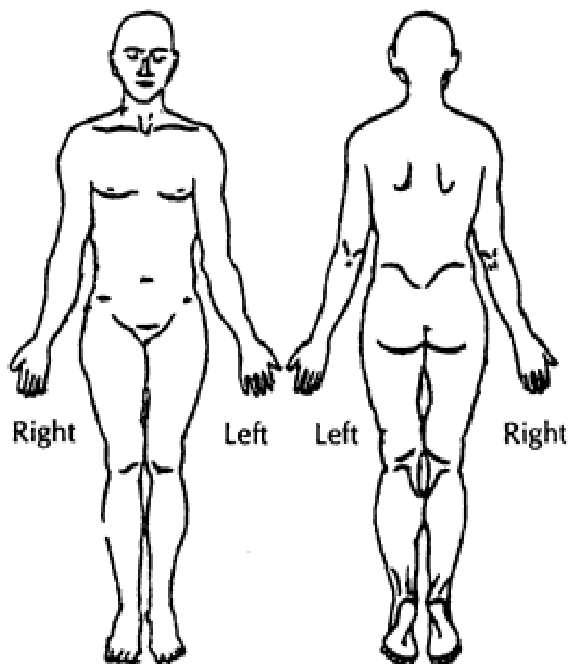
Additional Comments or Suggestions:

Mark the diagram below to indicate area(s) injured
Only one diagram per employee

Employee: ______________________



Employee: __________________________



X____ ____________________
(Name and title, if applicable, or person submitting above information) (Date)

X____ ____________________
(Department Head) (Date)

Fleet Maintenance and Human Resources Department Use Only

Vehicle Damage Assessment: ____

____

Fleet Manager's Observation: ____

____

Estimated repair cost $________________ Work Order #__________________ Case# _______________

How long will this unit be down due to the nature of the damage? ______________________

 Revised 05/2016