

HOUSTON COUNTY ACCIDENT / INCIDENT REPORT
PRELIMINARY INVESTIGATION

BACKGROUND INFORMATION:			
Accident/Incident Occurred:	Date:	Time:	Day of the Week Accident Happened:
Accident /Incident Reported:	Date:	Time:	___(M) ___(T) ___(W) ___(T)
Accident/Incident Investigation Began:	Date:	Time:	___(F) ___(Sa) ___(S)

___ WORKER'S COMP ONLY ___ LIABILITY ONLY ___ WORKER'S COMP & LIABILITY

EMPLOYEE INFORMATION	
Name (Last, First, MI)	Job Title at time of Injury / Illness:
	# Years in Job Position:
Home Address:	Supv. at Time of Injury / Illness:
	Location at time of Injury/Illness:
Phone #:	Witness(es):
Date of Birth:	

NON EMPLOYEE INFORMATION (CLAIMANT) Fill out if another party was involved in the Accident / Incident	
Claimant Name: (Last, First, MI)	Address:
Phone Number:	

ACCIDENT / INCIDENT LEVEL		
A. No Injury	B. Injury	
___ At Risk Behavior	___ Record Only	___ Lost Time
___ Near Miss	___ First Aid by Employer	___ Fatality
___ Property Damage	___ Medical Treatment	___ Other
Description of Injury or Illness, Part of Body Affected and Treatment Received: (Check if Drug Test Only <input type="checkbox"/>)		
Doctor / Hospital Name and Address:		
Description of Accident / Incident:		
Corrective Actions taken to prevent recurrence:		

Also complete the reverse side (or page 2) if the accident involves a motorized vehicle

Employee's Signature: _____

Person Completing Form: _____

Contact Phone #: _____

HOUSTON COUNTY ACCIDENT / INCIDENT REPORT

Complete this form if the accident/incident is related to a motorized vehicle.

COUNTY VEHICLE:	
Driver:	
Address:	
Telephone:	
Driver's License:	
Date of Birth:	
Owner of Vehicle:	
Make, Model, & Year of Vehicle:	
Tag Number:	
County Vehicle ID#:	

OTHER VEHICLE:	
Driver:	
Address:	
Telephone:	
Driver's License:	
Date of Birth:	
Owner of Vehicle:	
Make, Model, & Year of Vehicle:	
Tag Number:	

LOCATION OF ACCIDENT / INCIDENT:

DESCRIPTION OF ACCIDENT:

Witness(es)	
Name:	Name:
Address:	Address:
Phone #:	Phone #:

Person Completing Form: _____ Phone # _____