



*** Please Read ***

This PDF file contains the reporting forms for every department with respect to documenting accidents and/or incidents involving City employees, city property and the public. Some forms are common to all departments. To enhance clarity, the following pages include...

- (1) instructions that explain which forms should be used considering the scenario.
- (2) a memo that outlines the forms that are particular to each department.
- (3) instructions for requesting the forms from the stock room and/or the GSA print shop. Because these forms are meant to be used with the provided carbon copy sheets, a sufficient amount should be stored in your department.

If you have further clarification, please contact Patrice Rey or Robert Uria at 305-416-1732.

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How do I know which form to use?



SUPERVISOR'S REPORT OF EMPLOYEE ACCIDENT/INJURY - General Employees (AFSCME & Non-union)

- This form is to be completed for employees that report injuries AND are AFSCME and/or non-sworn employees. Sworn personnel should **not** use this form.

SUPERVISOR'S REPORT OF VEHICLE ACCIDENT

- This form is to be completed when any employee has been involved in a moving vehicle accident while driving a city vehicle.



How do I know which form to use?



REPORT OF INCIDENT/PROPERTY DAMAGE

- This form is to be completed:
 - (1) when an employee or visitor reports any type of property damage including vehicle damage not related to a moving accident.
 - (2) to report other types of occurrences as indicated on the form.
 - (3) to report allegations of injury sustained by a visitor on City property, other than in Parks.


SUPERVISOR'S REPORT OF EMPLOYEE ACCIDENT/INJURY – “Department Specific”

- As stated in the title of the individual documents, these forms are designated for either Fire and Police (sworn employees) and for either Parks, Public Works, GSA, and Solid Waste (Operations Employees) that report an injury. You should complete the GENERAL EMPLOYEES Accident/Injury form **ONLY** if you are non-sworn or if you are not an operations employee.

VISITOR ACCIDENT/INJURY REPORT - Parks & Recreation

- This form is to be completed for non-employees (visitors) that report an injury at a Parks & Recreation facility.

INTER-OFFICE MEMORANDUM

TO :	DEPARTMENT DIRECTORS	DATE :	July 10, 2008	FILE :
		SUBJECT :	New Risk Management Reporting Forms	
FROM :	Larry Spring Chief Financial Officer 	REFERENCES :		
		ENCLOSURES:	Attached	

The Safety Unit in the Risk Management Department has developed new reporting forms for injuries and accidents. These forms are to be used effective today. Please discontinue the use of the previous reporting forms.

Departmental specific reporting forms for employee injuries have been created for the following:

- Operational personnel in Parks, Public Works, Solid Waste, GSA and sworn members of Fire-Rescue and Police. All non-operational and non-sworn personnel are to utilize the Supervisor's Report of Employee Accident/Injury for General Employees.
- New Parks and Recreation form to report public allegations of injury/property damage

The following forms are available to all departments.

- New City-wide form for all departments to report vehicular accidents and other property damage and/or injury incidents
- New City-wide form for all departments to report general safety incidents and/or hazardous conditions.

Listed below are the departments and their applicable forms. To enhance clarity, the forms that each department has in common have been made bold and italicized.

(1) GSA

- Supervisor Report of Employee Accident/Injury - Operations Employees
- ***Supervisor Report of Employee Accident/Injury - General Employees***
- ***Supervisor Report of Vehicle Accident***
- ***Report of Incident/Property Damage***

(2) Parks and Recreation

- Supervisor Report of Employee Accident/Injury - Operations Employees
- Parks and Recreation Visitor Accident/Injury Report Form
- *Supervisor Report of Employee Accident/Injury - General Employees*
- *Supervisor Report of Vehicle Accident*
- *Report of Incident/Property Damage*

(3) Public Works

- Supervisor Report of Employee Accident/Injury - Operations Employees
- *Supervisor Report of Employee Accident/Injury - General Employees*
- *Supervisor Report of Vehicle Accident*
- *Report of Incident/Property Damage*

(4) Solid Waste

- Supervisor Report of Employee Accident/Injury - Operations Employees
- *Supervisor Report of Employee Accident/Injury - General Employees*
- *Supervisor Report of Vehicle Accident*
- *Report of Incident/Property Damage*

(5) Fire-Rescue

- Supervisor Report of Employee Accident/Injury - Sworn Employees
- *Supervisor Report of Employee Accident/Injury - General Employees*
- *Supervisor Report of Vehicle Accident*
- *Report of Incident/Property Damage*

(6) Police

- Supervisor Report of Employee Accident/Injury - Sworn Employees
- *Supervisor Report of Employee Accident/Injury - General Employees*
- *Supervisor Report of Vehicle Accident*
- *Report of Incident/Property Damage*

(7) All Other Departments

- *Supervisor Report of Employee Accident/Injury - General Employees*
- *Supervisor Report of Vehicle Accident*
- *Report of Incident/Property Damage*

The above departmental forms can be ordered by calling Scott Dempster at (305) 416-1912. Citywide forms can be obtained by completing a Requisition for Duplicating Services form for the City print shop. Eventually, all forms will be available via the Risk Management Department Intranet website. Should you have any questions regarding the forms, please contact Patrice Rey, Safety Manager at (305) 416-1732.

Your cooperation in this matter will be appreciated.



Instructions for Requesting Forms

Please use the forms attached as a guide in requesting the new Risk Management reporting forms. The form document number can be found in the bottom-left side of each of the forms enclosed.

D (Departmental) Forms: The forms with the letter “D” in the left hand corner can be ordered through the GSA Print Shop by completing the enclosed REQUISITION FOR DUPLICATING SERVICES form and sending it to (Milton Mizell: MMizell@miamigov.com or 305-329-4710).

C (City-wide) Forms: The forms with the letter “C” in the left hand corner are stored at the Purchasing Department and can be requested through (Scott Dempster: SDempster@miamigov.com or 305-416-1912).



City of Miami
General Employees (AFSCME & Non-Union)
SUPERVISOR'S REPORT OF EMPLOYEE ACCIDENT/INJURY

Instructions: This form must be completed by the supervisor and the claims network must be contacted at 1-877-647-4545 within 24 hours of occurrence.

EMPLOYEE INFORMATION	Name of Injured Employee: (include middle initial)		D.O.B. (MM/DD/YYYY):		
	Home Address:		Social Security #/Employee ID:		
	Telephone: Home: _____ Cellular: _____ Work: _____				
	Job Class/Title:		Dept.:	Shift:	
	Duty Hours:	Date of Employment (MM/DD/YYYY):		Hourly Rate:	Hours per Week:

ACCIDENT/INJURY INFORMATION	Date of Accident/Injury (MM/DD/YYYY):		Time of Accident/Injury: <input type="checkbox"/> AM <input type="checkbox"/> PM		
	Date Accident/Injury Reported (if different from above) (MM/DD/YYYY):	Did accident/injury occur during duty hours? <input type="checkbox"/> YES <input type="checkbox"/> NO	Safety equipment worn at time of injury? <input type="checkbox"/> YES <input type="checkbox"/> NO	Status: <input type="checkbox"/> TEMP <input type="checkbox"/> PERM	
	Previous injuries? <input type="checkbox"/> YES <input type="checkbox"/> NO	Exact location of accident/injury:			
	Briefly describe how accident/injury occurred:				
	Please provide any additional details you feel are pertinent to the accident:				
	List the names of any witnesses and contact info (if available):				

(A) Part of Body Injured (If more than one, check all that apply)	(B) Nature of Injury/Illness	(C) Activity Performed at Time of Accident	(D) Sources of Injury/Accident
<input type="checkbox"/> Abdomen <input type="checkbox"/> Ankle(s) (L) (R) <input type="checkbox"/> Arm(s) (L) (R) <input type="checkbox"/> Back <input type="checkbox"/> Breast(s) (L) (R) <input type="checkbox"/> Buttock(s) (L) (R) <input type="checkbox"/> Cheek(s) <input type="checkbox"/> Chest <input type="checkbox"/> Ear(s) (L) (R) <input type="checkbox"/> Elbow(s) (L) (R) <input type="checkbox"/> Eye(s) (L) (R) <input type="checkbox"/> Finger(s) (LH)(RH) <input type="checkbox"/> Foot/Feet (L) (R) <input type="checkbox"/> Groin (L) (R) <input type="checkbox"/> Hand(s) (L) (R) <input type="checkbox"/> Head/Neck Area <input type="checkbox"/> Heart <input type="checkbox"/> Hip(s) (L) (R) <input type="checkbox"/> Knee(s) (L) (R) <input type="checkbox"/> Leg(s) (L) (R) <input type="checkbox"/> Lip(s) <input type="checkbox"/> Lung(s) (L) (R) <input type="checkbox"/> Nose <input type="checkbox"/> Shoulder(s) (L) (R) <input type="checkbox"/> Stomach <input type="checkbox"/> Toe/Toes <input type="checkbox"/> Tooth/Teeth (Upper/Lower) <input type="checkbox"/> Wrist(s) (L) (R) <input type="checkbox"/> Other (specify): _____	<input type="checkbox"/> Abrasion <input type="checkbox"/> Allergic Reaction <input type="checkbox"/> Amputation <input type="checkbox"/> Bite <input type="checkbox"/> Blunt Trauma <input type="checkbox"/> Bruise <input type="checkbox"/> Burn <input type="checkbox"/> Chest Pain <input type="checkbox"/> Choking/Suffocation <input type="checkbox"/> Dizziness/Nausea <input type="checkbox"/> Electric Shock <input type="checkbox"/> Exposure <input type="checkbox"/> Food Poisoning <input type="checkbox"/> Foreign Body Eye/Ear <input type="checkbox"/> Fracture <input type="checkbox"/> Head Injury <input type="checkbox"/> Hearing Loss <input type="checkbox"/> Hernia <input type="checkbox"/> Laceration/Cut <input type="checkbox"/> Pain <input type="checkbox"/> Puncture/Stub Wound <input type="checkbox"/> Skin Condition <input type="checkbox"/> Slip/Trip/Fall <input type="checkbox"/> Smoke Inhalation <input type="checkbox"/> Strain/Sprain <input type="checkbox"/> Vision Loss <input type="checkbox"/> Other (specify): _____	<input type="checkbox"/> Bending <input type="checkbox"/> Climbing <input type="checkbox"/> Data Entry <input type="checkbox"/> Driving <input type="checkbox"/> Eating/Drinking <input type="checkbox"/> Entering/Exiting Property <input type="checkbox"/> Entering/Exiting Vehicle <input type="checkbox"/> Jumping <input type="checkbox"/> Kneeling <input type="checkbox"/> Lifting <input type="checkbox"/> Operating Equipment <input type="checkbox"/> Pulling/Pushing <input type="checkbox"/> Reaching <input type="checkbox"/> Repetitive Motion <input type="checkbox"/> Riding on Vehicle <input type="checkbox"/> Running <input type="checkbox"/> Sitting <input type="checkbox"/> Standing <input type="checkbox"/> Sweeping/Raking <input type="checkbox"/> Twisting <input type="checkbox"/> Walking <input type="checkbox"/> Other (specify): _____	<input type="checkbox"/> Animal/Insect <input type="checkbox"/> Assault/Battery <input type="checkbox"/> Blood/Body Fluid <input type="checkbox"/> Broken/Faulty Equipment <input type="checkbox"/> Chemical Agent <input type="checkbox"/> Collapsed Structure <input type="checkbox"/> Dust /Debris <input type="checkbox"/> Electrical Equipment <input type="checkbox"/> Environmental (heat, cold, noise) <input type="checkbox"/> Falling Object <input type="checkbox"/> Fire/Explosion <input type="checkbox"/> Food/Beverage/Medicine <input type="checkbox"/> Infectious Disease <input type="checkbox"/> Medical Condition <input type="checkbox"/> Office Equipment/Furniture/Machines <input type="checkbox"/> Personal Contact <input type="checkbox"/> Sharp/Blunt Instrument <input type="checkbox"/> Slippery/Wet Surface <input type="checkbox"/> Tools <input type="checkbox"/> Unforeseen Hazards (uneven sidewalks, pavements, broken glass, etc). <input type="checkbox"/> Vegetation <input type="checkbox"/> Vehicular Accident <input type="checkbox"/> Weapon <input type="checkbox"/> Other (specify): _____ List action(s) needed to prevent reoccurrence: _____

Did accident/injury require medical attention? YES NO If yes, name of facility: _____ First-aid only? YES NO

Did injury result in lost work/hours? YES NO Was managed care contacted? YES NO If yes, date: _____ Case #: _____

Supervisor Name: (print): _____ Spvs. Sgn.: _____ Tel. #: _____ Date: _____ | _____ | 20

Employee Name (print): _____ Employee Signature: _____ Date: _____ | _____ | 20

Departmental Safety Liaison (print): _____ Safety Liaison Signature: _____ Date: _____ | _____ | 20



City of Miami

REPORT OF INCIDENT / PROPERTY DAMAGE / INJURY

INSTRUCTIONS:

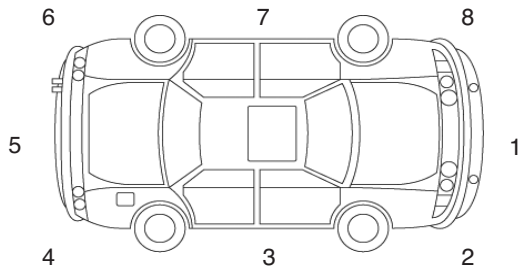
1. This form must be completed by the supervisor of the area where the incident occurred as soon as possible **on the same day** of the incident.
2. **DO NOT** use this form to report employee injuries. Use the appropriate SUPERVISOR'S REPORT OF EMPLOYEE ACCIDENT / INJURY form.
3. **DO NOT** use this form to report vehicle collisions. Use the SUPERVISOR'S VEHICLE COLLISION ACCIDENT / PROPERTY DAMAGE / PERSONAL INJURY REPORT.
4. **DO NOT** use this form for visitors that sustain an accident/injury in a City of Miami park. Use the Parks Dept. VISITOR ACCIDENT / INJURY REPORT FORM.
5. The claims network must be contacted at 1-877-647-4545 within 24 hours of occurrence.

Person Involved in Incident	Name of Individual: (include middle initial)		D.O.B. (MM/DD/YYYY):	
	Address:			
	Telephone:	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	Is the person involved a City of Miami employee? <input type="checkbox"/> YES <input type="checkbox"/> NO	
Location of Occurrence	Date of Incident (MM/DD/YYYY):		Time of Incident : <input type="checkbox"/> AM <input type="checkbox"/> PM	Check one: <input type="checkbox"/> No Injury <input type="checkbox"/> Personal Injury <input type="checkbox"/> Property Damage
	Previous injuries? <input type="checkbox"/> YES <input type="checkbox"/> NO	Exact Location of Incident :		Name of Dept./City Facility:
	Specific location where incident occurred:			
	List the names of any witnesses and contact info (if available):			
	Name: _____ Contact #: _____	Name: _____ Contact #: _____	Name: _____ Contact #: _____	Name: _____ Contact #: _____

Type of Incident (check one):

- | | | |
|--|--|---|
| <input type="checkbox"/> Aggressive/Violent Person | <input type="checkbox"/> Illness | <input type="checkbox"/> Suspicious Substance |
| <input type="checkbox"/> Bomb Threat | <input type="checkbox"/> Near Miss Accident | <input type="checkbox"/> Vehicle Damage |
| <input type="checkbox"/> Chemical Exposure | <input type="checkbox"/> Potential Health Exposure | <input type="checkbox"/> Other (please explain in Incident Details) |
| <input type="checkbox"/> Electrical Discharge/Short-circuit/Overload | <input type="checkbox"/> Property Damage/Vandalism | _____ |
| <input type="checkbox"/> Fire/Explosion | <input type="checkbox"/> Robbery/Assault | _____ |
| <input type="checkbox"/> Gas Leak | <input type="checkbox"/> Slip/Fall | _____ |
| <input type="checkbox"/> Hazardous Condition | <input type="checkbox"/> Suspicious Person | _____ |

Action Taken (if any): _____

Incident Details	Vehicle Information (if applicable)
List specific damages: _____ _____ _____ _____ _____	Circle number areas of vehicle damage: 

Was first-aid rendered? YES NO If yes, specify type rendered and by whom: _____

Was injured transported to facility? YES NO If yes, list facility name and means of transport: _____

Was the claims network contacted? YES NO If yes, date: _____ Case #: _____

Supervisor Name: (print): _____ Spvs. Sgn.: _____ Tel. #: _____ Date: ____/____/20__

Employee Name (print): _____ Employee Signature: _____ Date: ____/____/20__



City of Miami SUPERVISOR'S REPORT OF VEHICLE ACCIDENT

INSTRUCTIONS:

1. Call the Claims Network at 1-877-647-4545 to report the accident within 24 hours of the incident.
2. Use this form to report vehicle accidents and accidents/incidents resulting in personal injury and/or property damage.
3. If accident resulted in injury to employee, complete a Supervisor's Report of Employee Accident/Injury Form.
4. An estimate of damages for vehicles must be sent to Gallagher Bassett Services within 5 days.

Accident Location	Date of Accident (MM/DD/YYYY):		Date Reported (MM/DD/YYYY):		Road Conditions: <input type="checkbox"/> Wet <input type="checkbox"/> Dry <input type="checkbox"/> Other, Describe:	
	Exact Location/Address:					Time of Accident: <input type="checkbox"/> AM <input type="checkbox"/> PM
	Category of Accident: <input type="checkbox"/> Backing Up <input type="checkbox"/> Making a Turn <input type="checkbox"/> Lane Change <input type="checkbox"/> Head on Collision <input type="checkbox"/> Sideswipe <input type="checkbox"/> Making a U-turn <input type="checkbox"/> Rear-end Collision <input type="checkbox"/> Other:					
Information of Driver of City Vehicle	Driver's Name: (include middle initial)			Department/Division:		
	Driver's License #:		D.O.B. (MM/DD/YYYY):		Passengers injured? <input type="checkbox"/> YES <input type="checkbox"/> NO	
	Were passengers in vehicle? <input type="checkbox"/> YES <input type="checkbox"/> NO If yes, list names:					
	List type of injury/body part(s) involved (if known):					
	Transported to medical facility? <input type="checkbox"/> YES <input type="checkbox"/> NO If yes, list medical facility and means of transportation:					
Property Damage Information		Check what type of property allegedly was damaged: <input type="checkbox"/> Automobile <input type="checkbox"/> Building <input type="checkbox"/> Fences <input type="checkbox"/> Landscaping <input type="checkbox"/> Vehicle <input type="checkbox"/> Other:				
Other Party(s) Involved Information	Driver's Name: (include middle initial)					
	Driver injured? <input type="checkbox"/> YES <input type="checkbox"/> NO		Daytime Phone:		Evening Phone:	
	Were passengers in vehicle? <input type="checkbox"/> YES <input type="checkbox"/> NO If yes, list names:					
	List type of injury/body part(s) involved (if known):					
	Transported to medical facility? <input type="checkbox"/> YES <input type="checkbox"/> NO If yes, list medical facility and means of transportation:					
	Accident investigated by a law enforcement agency? <input type="checkbox"/> YES <input type="checkbox"/> NO If yes, list agency name:					
	Were photographs taken at the scene? <input type="checkbox"/> YES <input type="checkbox"/> NO If yes, by whom?					
Witness Information		Name of Witness(s)			Phone:	
Home Address(s):			City:		State:	Zip:
Description of the accident/incident (state only the facts):						
Mode of service at time of accident: <input type="checkbox"/> Emergency Response <input type="checkbox"/> Parked <input type="checkbox"/> Routing Driving <input type="checkbox"/> Backing			Devices in Use: <input type="checkbox"/> Visual <input type="checkbox"/> Audible <input type="checkbox"/> None <input type="checkbox"/> Lights <input type="checkbox"/> N/A			
Accident Details						
Please complete this diagram. Indicate names of the streets, direction, position of vehicles and point of contact. Use a solid line to show path before the accident and a dotted line to show the path after the accident. Use the symbols of the legend to recreate the scene.						
SYMBOLS/LEGEND: C City Vehicle O Other Vehicle Stop Sign Yield Sign Stop Light X Pedestrian						
			<p>Indicate the appropriate letter(s) for damaged areas on vehicle diagram (C=City Vehicle O=Other Vehicle)</p>			
<p>Scope of Employee Responsibility Statement As the driver of the City of Miami owned vehicle described in this report, I acknowledge that all information provided to the supervisor is true and correct to the best of my knowledge.</p> <p>Signature of Driver Required _____ Date _____/_____/20</p>			<p>Scope of Supervisor Responsibility Statement As the supervisor of this position, I affirm that the individual named driver was operating the vehicle within his or her authorized scope of employment at the time of the accident.</p> <p>Signature of Supervisor Required _____ Date _____/_____/20</p>			
Was the claims network above notified/contacted? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, person notified:						
Time Notified: <input type="checkbox"/> AM <input type="checkbox"/> PM			Date Notified (MM/DD/YYYY):			
Report Prepared By (print name) _____		Title _____		Signature _____		Date _____/_____/20
Supervisor (print name) _____		Title _____		Signature _____		Date _____/_____/20
Report Reviewed By (print name) _____		Title _____		Signature _____		Date _____/_____/20



City of Miami
Police Department (Sworn Employees Only)
SUPERVISOR'S REPORT OF EMPLOYEE ACCIDENT/INJURY

Instructions: This form must be completed by the supervisor and the claims network must be contacted at 1-877-647-4545 within 24 hours of occurrence.

EMPLOYEE INFORMATION	Name of Injured Employee: (include middle initial)			D.O.B. (MM/DD/YYYY):	
	Title/Division:	IBM No.:	Section:	Unit:	
	Home Address:			Social Security #:	
	Telephone: Home: _____ Cellular: _____ Work: _____			Shift:	
	Duty Hours:	Date of Employment (MM/DD/YYYY):	Hourly Rate:	Hours per Week:	

ACCIDENT/INJURY INFORMATION	Date of Accident/Injury (MM/DD/YYYY):		Time of Accident/Injury: <input type="checkbox"/> AM <input type="checkbox"/> PM		
	Date Accident/Injury Reported (if different from above) (MM/DD/YYYY):		Did accident/injury occur at emergency incident? <input type="checkbox"/> YES <input type="checkbox"/> NO		
	Previous injuries? <input type="checkbox"/> YES <input type="checkbox"/> NO		Safety equipment worn at time of injury? <input type="checkbox"/> YES <input type="checkbox"/> NO		
	Exact Location of Accident/Injury:				
	Briefly describe how accident/injury occurred:				
	Please provide any additional details you feel are pertinent to the accident:				
List the names of any witnesses and contact info (if available):					
Name: _____		Contact #: _____		Name: _____	
Name: _____		Contact #: _____		Name: _____	

(A) Part of Body Injured <small>(If more than one, check all that apply)</small>	(B) Nature of Injury/Illness	(C) Activity Performed at Time of Accident	(D) Sources of Injury/Accident
<input type="checkbox"/> Abdomen <input type="checkbox"/> Ankle(s) (L) (R) <input type="checkbox"/> Arm(s) (L) (R) <input type="checkbox"/> Back <input type="checkbox"/> Breast(s) (L) (R) <input type="checkbox"/> Buttock(s) (L) (R) <input type="checkbox"/> Cheek(s) <input type="checkbox"/> Chest <input type="checkbox"/> Ear(s) (L) (R) <input type="checkbox"/> Elbow(s) (L) (R) <input type="checkbox"/> Exposure (multiple body parts) <input type="checkbox"/> Eye(s) (L) (R) <input type="checkbox"/> Finger(s) (LH)(RH) <input type="checkbox"/> Foot/Feet (L) (R) <input type="checkbox"/> Groin (L) (R) <input type="checkbox"/> Hand(s) (L) (R) <input type="checkbox"/> Head/Neck Area <input type="checkbox"/> Heart <input type="checkbox"/> Hip(s) (L) (R) <input type="checkbox"/> Knee(s) (L) (R) <input type="checkbox"/> Leg(s) (L) (R) <input type="checkbox"/> Lip(s) <input type="checkbox"/> Lung(s) (L) (R) <input type="checkbox"/> Nose <input type="checkbox"/> Shoulder(s) (L) (R) <input type="checkbox"/> Stomach <input type="checkbox"/> Toe/Toes <input type="checkbox"/> Tooth/Teeth (Upper/Lower) <input type="checkbox"/> Wrist(s) (L) (R) <input type="checkbox"/> Other (specify): _____	<input type="checkbox"/> Abrasion <input type="checkbox"/> Allergic Reaction <input type="checkbox"/> Amputation <input type="checkbox"/> Bite <input type="checkbox"/> Blunt Trauma <input type="checkbox"/> Bruise <input type="checkbox"/> Bullet Wound <input type="checkbox"/> Burn <input type="checkbox"/> Chest Pain <input type="checkbox"/> Choking/Suffocation <input type="checkbox"/> Contusion <input type="checkbox"/> Dizziness/Nausea <input type="checkbox"/> Drowning/Near Drowning <input type="checkbox"/> Electric Shock <input type="checkbox"/> Exposure <input type="checkbox"/> Food Poisoning <input type="checkbox"/> Foreign Body Eye/Ear <input type="checkbox"/> Fracture <input type="checkbox"/> Gunshot Wound <input type="checkbox"/> Head Injury <input type="checkbox"/> Hearing Loss <input type="checkbox"/> Heart Attack <input type="checkbox"/> Hypertension <input type="checkbox"/> Illness (unspecified) <input type="checkbox"/> Laceration/Cut <input type="checkbox"/> Pain <input type="checkbox"/> Puncture/Stub Wound <input type="checkbox"/> Slip/Trip/Fall <input type="checkbox"/> Smoke Inhalation <input type="checkbox"/> Strain/Sprain <input type="checkbox"/> Other (specify): _____	<input type="checkbox"/> Annual Physical <input type="checkbox"/> Bending <input type="checkbox"/> Climbing <input type="checkbox"/> Data Entry <input type="checkbox"/> Discharge Weapon <input type="checkbox"/> Driving <input type="checkbox"/> Eating/Drinking <input type="checkbox"/> Entering/Exiting Property <input type="checkbox"/> Entering/Exiting Vehicle <input type="checkbox"/> Jumping <input type="checkbox"/> Kneeling <input type="checkbox"/> Lifting <input type="checkbox"/> Medical Evaluation <input type="checkbox"/> Operating Equipment <input type="checkbox"/> Pulling/Pushing <input type="checkbox"/> Reaching <input type="checkbox"/> Repetitive Motion <input type="checkbox"/> Responding to Alarm <input type="checkbox"/> Restraining Subject <input type="checkbox"/> Riding Bicycle/Horse <input type="checkbox"/> Running <input type="checkbox"/> Sitting <input type="checkbox"/> Sports/Fitness Activity <input type="checkbox"/> Standing <input type="checkbox"/> Training Exercise <input type="checkbox"/> Transport <input type="checkbox"/> Walking <input type="checkbox"/> Water Rescue/Recovery <input type="checkbox"/> Other (specify): _____	<input type="checkbox"/> Animal/Insect <input type="checkbox"/> Assault/Battery <input type="checkbox"/> Automobile/Boat Accident <input type="checkbox"/> Blood/Body Fluid <input type="checkbox"/> Broken/Faulty Equipment <input type="checkbox"/> Chemical Agent <input type="checkbox"/> Dust/Debris <input type="checkbox"/> Electrical Equipment <input type="checkbox"/> Environmental (heat, cold, noise, smoke) <input type="checkbox"/> Excessive Noise <input type="checkbox"/> Falling Object <input type="checkbox"/> Fire Explosion <input type="checkbox"/> Firearms/Weapons <input type="checkbox"/> Food/Beverage/Medicine <input type="checkbox"/> Medical Condition <input type="checkbox"/> Office Equipment/Furniture/Machines <input type="checkbox"/> Personal Contact <input type="checkbox"/> Sharp/Blunt Instrument <input type="checkbox"/> Slippery/Wet Surface <input type="checkbox"/> Tools <input type="checkbox"/> Unforeseen Hazards (uneven sidewalks, broken glass, etc). <input type="checkbox"/> Vegetation <input type="checkbox"/> Weapon <input type="checkbox"/> Other (specify): _____ List action(s) needed to prevent recurrence: _____

Did accident/injury require medical attention? YES NO If yes, name of facility: _____ First-aid only? YES NO

Did injury result in lost work/hours? YES NO Was managed care contacted? YES NO If yes, date: _____ Case #: _____

Supervisor Name: (print) _____ Spvs. Sgn.: _____ Tel. #: _____ Date: _____ | _____ | 20

Employee Name (print): _____ Employee Signature: _____ Date: _____ | _____ | 20

Departmental Safety Liaison (print): _____ Safety Liaison Signature: _____ Date: _____ | _____ | 20



City of Miami
Fire-Rescue (Sworn Employees Only)
SUPERVISOR'S REPORT OF EMPLOYEE ACCIDENT/INJURY

Instructions: This form must be completed by the supervisor and the claims network must be contacted at 1-877-647-4545 within 24 hours of occurrence.

EMPLOYEE INFORMATION	Employee Name: (include middle initial)			D.O.B. (MM/DD/YYYY):		Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female		
	Title:	Division:	Badge#:	Station:	Shift:	Unit:		
	Home Address:					Social Security #:		
	Telephone: Home:		Cellular:		Work:			

ACCIDENT/INJURY INFORMATION	Date of Accident/Injury (MM/DD/YYYY):			Time of Accident/Injury: <input type="checkbox"/> AM <input type="checkbox"/> PM				
	Date Accident/Injury Reported (if different from above) (MM/DD/YYYY):			Did accident/injury occur at emergency incident? <input type="checkbox"/> YES <input type="checkbox"/> NO Alarm No.:		HazMat emergency? <input type="checkbox"/> YES <input type="checkbox"/> NO		
	Location of accident/injury (not address):					Personnel off. notified? <input type="checkbox"/> YES <input type="checkbox"/> NO		
	Responding to alarm? <input type="checkbox"/> YES <input type="checkbox"/> NO If Yes, Alarm No.:					Previous injuries? <input type="checkbox"/> YES <input type="checkbox"/> NO		
	Briefly describe how accident/injury occurred:					Did accident occur at station? <input type="checkbox"/> YES <input type="checkbox"/> NO		
	Please provide any additional details you feel are pertinent to the accident:							
	List the names of any witnesses and contact info (if available):				Check/list any PPE associated with this injury:			Was there PPE failure?

Name: _____ Contact #: _____	<input type="checkbox"/> Bunker Coat <input type="checkbox"/> Dive Gear <input type="checkbox"/> Eye Protection <input type="checkbox"/> Helmet	<input type="checkbox"/> YES
Name: _____ Contact #: _____	<input type="checkbox"/> Foot Protection <input type="checkbox"/> Gloves <input type="checkbox"/> Hearing Protection <input type="checkbox"/> Hood	<input type="checkbox"/> NO
	<input type="checkbox"/> Bunker Pants <input type="checkbox"/> Seat Belts <input type="checkbox"/> PASS <input type="checkbox"/> SCBA	
	<input type="checkbox"/> Other:	

(A) Part of Body Injured (If more than one, check all that apply)	(B) Nature of Injury/Illness	(C) Activity Performed at Time of Accident	(D) Sources of Injury/Accident
<input type="checkbox"/> Abdomen <input type="checkbox"/> Ankle(s) (L) (R) <input type="checkbox"/> Arm(s) (L) (R) <input type="checkbox"/> Back <input type="checkbox"/> Breast(s) (L) (R) <input type="checkbox"/> Buttock(s) (L) (R) <input type="checkbox"/> Cheek(s) <input type="checkbox"/> Chest <input type="checkbox"/> Ear(s) (L) (R) <input type="checkbox"/> Elbow(s) (L) (R) <input type="checkbox"/> Exposure (multiple body parts) <input type="checkbox"/> Eye(s) (L) (R) <input type="checkbox"/> Finger(s) (LH)(RH) <input type="checkbox"/> Foot/Feet (L) (R) <input type="checkbox"/> Groin (L) (R) <input type="checkbox"/> Hand(s) (L) (R) <input type="checkbox"/> Head/Neck Area <input type="checkbox"/> Heart <input type="checkbox"/> Hip(s) (L) (R) <input type="checkbox"/> Knee(s) (L) (R) <input type="checkbox"/> Leg(s) (L) (R) <input type="checkbox"/> Lip(s) <input type="checkbox"/> Lung(s) (L) (R) <input type="checkbox"/> Nose <input type="checkbox"/> Shoulder(s) (L) (R) <input type="checkbox"/> Stomach <input type="checkbox"/> Toe/Toes <input type="checkbox"/> Tooth/Teeth (Upper/Lower) <input type="checkbox"/> Wrist(s) (L) (R) <input type="checkbox"/> Other (specify): _____	<input type="checkbox"/> Abrasion <input type="checkbox"/> Allergic Reaction <input type="checkbox"/> Altered Mental Status (AMS) <input type="checkbox"/> Amputation <input type="checkbox"/> Bite <input type="checkbox"/> Bleeding <input type="checkbox"/> Blunt Trauma <input type="checkbox"/> Bruise <input type="checkbox"/> Burn <input type="checkbox"/> Chest Pain <input type="checkbox"/> Choking/Suffocation <input type="checkbox"/> Dizziness/Nausea <input type="checkbox"/> Drowning/Near Drowning <input type="checkbox"/> Electric Shock <input type="checkbox"/> Exposure <input type="checkbox"/> Food Poisoning <input type="checkbox"/> Foreign Body Eye/Ear <input type="checkbox"/> Fracture <input type="checkbox"/> Gunshot Wound <input type="checkbox"/> Head Injury <input type="checkbox"/> Hearing Loss <input type="checkbox"/> Heart Attack <input type="checkbox"/> Hypertension <input type="checkbox"/> Illness (unspecified) <input type="checkbox"/> Laceration/Cut <input type="checkbox"/> Pain <input type="checkbox"/> Puncture/Stab Wound <input type="checkbox"/> Skin Condition <input type="checkbox"/> Slip/Trip/Fall <input type="checkbox"/> Smoke Inhalation <input type="checkbox"/> Strain/Sprain <input type="checkbox"/> Vision Loss <input type="checkbox"/> Other (specify): _____	<input type="checkbox"/> Annual Physical <input type="checkbox"/> Bending <input type="checkbox"/> Climbing <input type="checkbox"/> Data Entry <input type="checkbox"/> Driving <input type="checkbox"/> Eating/Drinking <input type="checkbox"/> Entering/Exiting Property <input type="checkbox"/> Entering/Exiting Vehicle <input type="checkbox"/> Fire Suppression <input type="checkbox"/> Jumping <input type="checkbox"/> Kitchen Activity <input type="checkbox"/> Kneeling <input type="checkbox"/> Lifting <input type="checkbox"/> Medical Evaluation <input type="checkbox"/> Operating Equipment <input type="checkbox"/> Pulling/Pushing <input type="checkbox"/> Reaching <input type="checkbox"/> Repetitive Motion <input type="checkbox"/> Rescue Operation <input type="checkbox"/> Riding on Vehicle <input type="checkbox"/> Running <input type="checkbox"/> Sitting <input type="checkbox"/> Sports/Fitness Activity <input type="checkbox"/> Standing <input type="checkbox"/> Station Maint. Activity <input type="checkbox"/> Training Exercise <input type="checkbox"/> Transport <input type="checkbox"/> Walking <input type="checkbox"/> Water Rescue/Recovery <input type="checkbox"/> Other (specify): _____	<input type="checkbox"/> Animal/Insect <input type="checkbox"/> Assault/Battery <input type="checkbox"/> Blood/Body Fluid <input type="checkbox"/> Broken/Faulty Equipment <input type="checkbox"/> Chemical Agent <input type="checkbox"/> Collapsed Structure <input type="checkbox"/> Dust /Debris <input type="checkbox"/> Electrical Equipment <input type="checkbox"/> Environmental (heat, cold, noise, smoke) <input type="checkbox"/> Falling Object <input type="checkbox"/> Fire/Explosion <input type="checkbox"/> Fire Fighting Apparatus <input type="checkbox"/> Food/Beverage/Medicine <input type="checkbox"/> Infectious Disease <input type="checkbox"/> Medical Condition <input type="checkbox"/> Office Equipment/Furniture/Machines <input type="checkbox"/> Patient Transport Equipment <input type="checkbox"/> Personal Contact <input type="checkbox"/> Sharp/Blunt Instrument <input type="checkbox"/> Slippery/Wet Surface <input type="checkbox"/> Tools <input type="checkbox"/> Unforeseen Hazards (uneven sidewalks, broken glass, etc). <input type="checkbox"/> Vegetation <input type="checkbox"/> Vehicular Accident <input type="checkbox"/> Weapon <input type="checkbox"/> Other (specify): _____ List action(s) needed to prevent recurrence: _____

Did accident/injury require medical attention? YES NO If yes, name of facility: _____

First-aid only? YES NO Did injury result in lost work/hours? YES NO If yes, date: _____

Was managed care contacted? YES NO If yes, date: _____ Case #: _____ Info entered in station journal? YES NO

Supervisor Name: (print): _____ Spvs. Sgn.: _____ Tel. #: _____ Date: _____/_____/20____

Employee Name (print): _____ Employee Signature: _____ Date: _____/_____/20____

Dist./Div. Chief Name (print): _____ Dist./Div. Chief Signature: _____ Date: _____/_____/20____

Departmental Safety Liaison (print): _____ Safety Liaison Signature: _____ Date: _____/_____/20____



City of Miami
Parks & Recreation - Operations Employee Only
SUPERVISOR'S REPORT OF EMPLOYEE ACCIDENT/INJURY

Instructions: This form must be completed by the supervisor and the claims network must be contacted at 1-877-647-4545 within 24 hours of occurrence.

EMPLOYEE INFORMATION	Name of Injured Employee: (include middle initial)		D.O.B. (MM/DD/YYYY):		
	Home Address:		Social Security #/Employee ID:		
	Telephone: Home: _____ Cellular: _____ Work: _____				
	Shift:	Title:			
	Duty Hours:	Date of Employment (MM/DD/YYYY):	Hourly Rate:	Hours per Week:	

ACCIDENT/INJURY INFORMATION	Date of Accident/Injury (MM/DD/YYYY):		Time of Accident/Injury: <input type="checkbox"/> AM <input type="checkbox"/> PM		
	Date Accident/Injury Reported (if different from above) (MM/DD/YYYY):	Did accident/injury occur during duty hours? <input type="checkbox"/> YES <input type="checkbox"/> NO	Safety equipment worn at time of injury? <input type="checkbox"/> YES <input type="checkbox"/> NO	Status: <input type="checkbox"/> TEMP <input type="checkbox"/> PERM	
	Previous injuries? <input type="checkbox"/> YES <input type="checkbox"/> NO	Exact Location of Accident/Injury:		Park Name/Location:	
	Briefly describe how accident/injury occurred:				
	Please provide any additional details you feel are pertinent to the accident:				
	List the names of any witnesses and contact info (if available):				

Name: _____	Contact #: _____	Name: _____	Contact #: _____
Name: _____	Contact #: _____	Name: _____	Contact #: _____

(A) Part of Body Injured <small>(If more than one, check all that apply)</small>	(B) Nature of Injury/Illness	(C) Activity Performed at Time of Accident	(D) Sources of Injury/Accident
<input type="checkbox"/> Abdomen <input type="checkbox"/> Ankle(s) (L) (R) <input type="checkbox"/> Arm(s) (L) (R) <input type="checkbox"/> Back <input type="checkbox"/> Breast(s) (L) (R) <input type="checkbox"/> Buttock(s) (L) (R) <input type="checkbox"/> Cheek(s) <input type="checkbox"/> Chest <input type="checkbox"/> Ear(s) (L) (R) <input type="checkbox"/> Elbow(s) (L) (R) <input type="checkbox"/> Eye(s) (L) (R) <input type="checkbox"/> Finger(s) (LH)(RH) <input type="checkbox"/> Foot/Feet (L) (R) <input type="checkbox"/> Groin (L) (R) <input type="checkbox"/> Hand(s) (L) (R) <input type="checkbox"/> Head/Neck Area <input type="checkbox"/> Heart <input type="checkbox"/> Hip(s) (L) (R) <input type="checkbox"/> Knee(s) (L) (R) <input type="checkbox"/> Leg(s) (L) (R) <input type="checkbox"/> Lip(s) <input type="checkbox"/> Lung(s) (L) (R) <input type="checkbox"/> Nose <input type="checkbox"/> Shoulder(s) (L) (R) <input type="checkbox"/> Stomach <input type="checkbox"/> Toe/Toes <input type="checkbox"/> Tooth/Teeth (Upper/Lower) <input type="checkbox"/> Wrist(s) (L) (R) <input type="checkbox"/> Other (specify): _____	<input type="checkbox"/> Abrasion <input type="checkbox"/> Allergic Reaction <input type="checkbox"/> Amputation <input type="checkbox"/> Bite <input type="checkbox"/> Blunt Trauma <input type="checkbox"/> Bruise <input type="checkbox"/> Burn <input type="checkbox"/> Chest Pain <input type="checkbox"/> Choking/Suffocation <input type="checkbox"/> Dizziness/Nausea <input type="checkbox"/> Drowning/Near Drowning <input type="checkbox"/> Electric Shock <input type="checkbox"/> Exposure <input type="checkbox"/> Food Poisoning <input type="checkbox"/> Foreign Body Eye/Ear <input type="checkbox"/> Fracture <input type="checkbox"/> Head Injury <input type="checkbox"/> Hearing Loss <input type="checkbox"/> Hernia <input type="checkbox"/> Laceration/Cut <input type="checkbox"/> Pain <input type="checkbox"/> Puncture/Stub Wound <input type="checkbox"/> Rash <input type="checkbox"/> Skin Condition <input type="checkbox"/> Slip/Trip/Fall <input type="checkbox"/> Smoke Inhalation <input type="checkbox"/> Strain/Sprain <input type="checkbox"/> Other (specify): _____	<input type="checkbox"/> Bending <input type="checkbox"/> Climbing <input type="checkbox"/> Data Entry <input type="checkbox"/> Diving/Swimming <input type="checkbox"/> Driving <input type="checkbox"/> Eating/Drinking <input type="checkbox"/> Entering/Exiting Property <input type="checkbox"/> Entering/Exiting Vehicle <input type="checkbox"/> Jumping <input type="checkbox"/> Kneeling <input type="checkbox"/> Landscape Functions <input type="checkbox"/> Lifting <input type="checkbox"/> Maintenance Activities <input type="checkbox"/> Operating Equipment <input type="checkbox"/> Painting <input type="checkbox"/> Pulling/Pushing <input type="checkbox"/> Reaching <input type="checkbox"/> Rendering Aid <input type="checkbox"/> Repetitive Motion <input type="checkbox"/> Riding on Vehicle <input type="checkbox"/> Running <input type="checkbox"/> Sitting <input type="checkbox"/> Sports Activity <input type="checkbox"/> Standing <input type="checkbox"/> Sweeping/Raking <input type="checkbox"/> Transporting Materials <input type="checkbox"/> Twisting <input type="checkbox"/> Using Hand Power Tools <input type="checkbox"/> Walking <input type="checkbox"/> Other (specify): _____	<input type="checkbox"/> Animal/Insect <input type="checkbox"/> Assault/Battery <input type="checkbox"/> Blood/Body Fluid <input type="checkbox"/> Broken/Faulty Equipment <input type="checkbox"/> Chemical Agent <input type="checkbox"/> Collapsed Structure <input type="checkbox"/> Dust/Debris <input type="checkbox"/> Electrical Equipment <input type="checkbox"/> Environmental (heat, cold, noise) <input type="checkbox"/> Falling Object <input type="checkbox"/> Fire/Explosion <input type="checkbox"/> Food/Beverage/Medicine <input type="checkbox"/> Infectious Disease <input type="checkbox"/> Medical Condition <input type="checkbox"/> Office Equipment/Furniture/Machines <input type="checkbox"/> Personal Contact <input type="checkbox"/> Pulling Object <input type="checkbox"/> Sharp/Blunt Instrument <input type="checkbox"/> Slippery/Wet Surface <input type="checkbox"/> Tools <input type="checkbox"/> Unforeseen Hazards (uneven sidewalks, pavements, broken glass, etc). <input type="checkbox"/> Vegetation <input type="checkbox"/> Vehicular Accident <input type="checkbox"/> Weapon <input type="checkbox"/> Other (specify): _____ List action(s) needed to prevent reoccurrence: _____

Did accident/injury require medical attention? YES NO If yes, name of facility: _____ First-aid only? YES NO

Did injury result in lost work/hours? YES NO Was managed care contacted? YES NO If yes, date: _____ Case #: _____

Supervisor Name: (print) : _____ Spvs. Sgn.: _____ Tel. #: _____ Date: _____ | _____ | 20__

Employee Name (print) : _____ Employee Signature: _____ Date: _____ | _____ | 20__

Departmental Safety Liaison (print) : _____ Safety Liaison Signature: _____ Date: _____ | _____ | 20__



City of Miami Parks & Recreation VISITOR ACCIDENT/INJURY REPORT

Instructions: This form must be completed by the supervisor and the claims network must be contacted at 1-877-647-4545 within 24 hours of occurrence.

VISITOR INFO	Name of Injured: (include middle initial)		D.O.B. (MM/DD/YYYY):
	Address:		
	Daytime Phone:	Evening Phone:	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female

ACCIDENT/INJURY INFO	Park Name/Location:		
	Date of Accident (MM/DD/YYYY):	Time of Accident: <input type="checkbox"/> AM <input type="checkbox"/> PM	
	Choose one: <input type="checkbox"/> After School Program <input type="checkbox"/> General Visitor <input type="checkbox"/> Parking Area <input type="checkbox"/> Summer Camp		

ACCIDENT LOCATION	<input type="checkbox"/> Ball Field <input type="checkbox"/> Basketball/Tennis Court <input type="checkbox"/> Day Care Facility <input type="checkbox"/> Gymnasium <input type="checkbox"/> Park Office <input type="checkbox"/> Parking Lot <input type="checkbox"/> Playground <input type="checkbox"/> Pool <input type="checkbox"/> Restroom <input type="checkbox"/> Other
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NATURE OF INJURY	<input type="checkbox"/> Abrasion <input type="checkbox"/> Exposure <input type="checkbox"/> Allergic Reaction <input type="checkbox"/> Food Poisoning <input type="checkbox"/> Amputation <input type="checkbox"/> Foreign Body into Eye/Ear <input type="checkbox"/> Bite <input type="checkbox"/> Foreign Body into Mouth <input type="checkbox"/> Blunt Trauma <input type="checkbox"/> Fracture <input type="checkbox"/> Burn <input type="checkbox"/> Hearing Loss <input type="checkbox"/> Chest Pain <input type="checkbox"/> Laceration/Cut <input type="checkbox"/> Choking/Suffocation <input type="checkbox"/> Pain <input type="checkbox"/> Concussion <input type="checkbox"/> Puncture/Stab Wound <input type="checkbox"/> Contusion <input type="checkbox"/> Rash <input type="checkbox"/> Dizziness/Nausea <input type="checkbox"/> Strain/Sprain <input type="checkbox"/> Drowning/Near Drowning <input type="checkbox"/> Other (specify): _____ <input type="checkbox"/> Electric Shock _____	BODY PART INJURED	<input type="checkbox"/> Abdomen <input type="checkbox"/> Ankle(s) (L) (R) <input type="checkbox"/> Arm(s) (L) (R) <input type="checkbox"/> Back <input type="checkbox"/> Breast(s) (L) (R) <input type="checkbox"/> Buttock(s) (L) (R) <input type="checkbox"/> Cheek(s) <input type="checkbox"/> Chest <input type="checkbox"/> Ear(s) (L) (R) <input type="checkbox"/> Elbow(s) (L) (R) <input type="checkbox"/> Eye(s) (L) (R) <input type="checkbox"/> Finger(s) (LH)(RH) <input type="checkbox"/> Foot/Feet (L) (R) <input type="checkbox"/> Groin (L) (R) <input type="checkbox"/> Hand(s) (L) (R)	<input type="checkbox"/> Head/Neck Area _____ <input type="checkbox"/> Heart <input type="checkbox"/> Hip(s) (L) (R) <input type="checkbox"/> Knee(s) (L) (R) <input type="checkbox"/> Leg(s) (L) (R) <input type="checkbox"/> Lip(s) <input type="checkbox"/> Lung(s) (L) (R) <input type="checkbox"/> Nose <input type="checkbox"/> Shoulder(s) (L) (R) <input type="checkbox"/> Stomach <input type="checkbox"/> Toe/Toes <input type="checkbox"/> Tooth/Teeth (Upper/Lower) <input type="checkbox"/> Wrist(s) (L) (R) <input type="checkbox"/> Other (specify): _____ _____
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CAUSE OF INJURY	<input type="checkbox"/> Animal/Insect <input type="checkbox"/> Contact with Sharp Object <input type="checkbox"/> Hit by Object <input type="checkbox"/> Unforeseen Hazards (uneven pavements, broken glass, etc.) <input type="checkbox"/> Assault/Altercation <input type="checkbox"/> Electrical Equipment <input type="checkbox"/> Medical Condition/Illness <input type="checkbox"/> Personal Contact <input type="checkbox"/> Vegetation <input type="checkbox"/> Collision with Person/Object <input type="checkbox"/> Environmental Condition <input type="checkbox"/> Trip/Fall/Slip Same Level
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ACTIVITY PERFORMED	<input type="checkbox"/> Baseball/Softball <input type="checkbox"/> Football <input type="checkbox"/> Soccer <input type="checkbox"/> Volleyball <input type="checkbox"/> Basketball <input type="checkbox"/> Kickball <input type="checkbox"/> Swimming/Diving <input type="checkbox"/> Watersports <input type="checkbox"/> Climbing <input type="checkbox"/> Running/Jumping/Walking <input type="checkbox"/> Swinging <input type="checkbox"/> Eating/Drinking <input type="checkbox"/> Sliding <input type="checkbox"/> Tennis
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Was fire-rescue/police contacted? YES NO If so, who?

Was individual transported to medical facility? YES NO If yes, list facility:

Was parent(s)/guardian(s) contacted? YES NO If yes, whom?

Was first-aid administered? YES NO If yes, list first-aid applied (i.e. elevation, pressure, cold packs, etc.):

Who administered first-aid?

Was equipment involved in injury? <input type="checkbox"/> YES <input type="checkbox"/> NO If yes, list equipment:	Was equipment used properly <input type="checkbox"/> YES <input type="checkbox"/> NO
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Was supervision present at time of accident/injury? YES NO

If accident involved loss/damage to property, please describe:

Park Mgr. Name: (print) _____ Signature: _____ Tel. #: _____ Date: ____/____/20____

Department Safety Liaison (print): _____ Signature: _____ Date: ____/____/20____



City of Miami Public Works - Operations Employees Only SUPERVISOR'S REPORT OF EMPLOYEE ACCIDENT/INJURY

Instructions: This form must be completed by the supervisor and the claims network must be contacted at 1-877-647-4545 within 24 hours of occurrence.

EMPLOYEE INFORMATION	Name of Injured Employee: (include middle initial)		D.O.B. (MM/DD/YYYY):	
	Home Address:		Social Security #/Employee ID:	
	Telephone:		Work:	
	Home:	Cellular:		
	Shift:	Job Class/Title:		
	Duty Hours:	Date of Employment (MM/DD/YYYY):	Hourly Rate:	Hours per Week:
ACCIDENT/INJURY INFORMATION	Date of Accident/Injury (MM/DD/YYYY):		Time of Accident/Injury: <input type="checkbox"/> AM <input type="checkbox"/> PM	
	Date Accident/Injury Reported (if different from above) (MM/DD/YYYY):	Did accident/injury occur during duty hours? <input type="checkbox"/> YES <input type="checkbox"/> NO	Safety equipment worn at time of injury? <input type="checkbox"/> YES <input type="checkbox"/> NO	
	Previous injuries? <input type="checkbox"/> YES <input type="checkbox"/> NO	Exact Location of Accident/Injury:		
	Briefly describe how accident/injury occurred:			
	Please provide any additional details you feel are pertinent to the accident:			
	List the names of any witnesses and contact info (if available):			
Name: _____ Contact #: _____		Name: _____ Contact #: _____		
Name: _____ Contact #: _____		Name: _____ Contact #: _____		
(A) Part of Body Injured <small>(If more than one, check all that apply)</small>	(B) Nature of Injury/Illness	(C) Activity Performed at Time of Accident	(D) Sources of Injury/Accident	
<input type="checkbox"/> Abdomen <input type="checkbox"/> Ankle(s) (L) (R) <input type="checkbox"/> Arm(s) (L) (R) <input type="checkbox"/> Back <input type="checkbox"/> Breast(s) (L) (R) <input type="checkbox"/> Buttock(s) (L) (R) <input type="checkbox"/> Cheek(s) <input type="checkbox"/> Chest <input type="checkbox"/> Ear(s) (L) (R) <input type="checkbox"/> Elbow(s) (L) (R) <input type="checkbox"/> Eye(s) (L) (R) <input type="checkbox"/> Finger(s) (LH)(RH) <input type="checkbox"/> Foot/Feet (L) (R) <input type="checkbox"/> Groin (L) (R) <input type="checkbox"/> Hand(s) (L) (R) <input type="checkbox"/> Head/Neck Area <input type="checkbox"/> Heart <input type="checkbox"/> Hip(s) (L) (R) <input type="checkbox"/> Knee(s) (L) (R) <input type="checkbox"/> Leg(s) (L) (R) <input type="checkbox"/> Lip(s) <input type="checkbox"/> Lung(s) (L) (R) <input type="checkbox"/> Nose <input type="checkbox"/> Shoulder(s) (L) (R) <input type="checkbox"/> Stomach <input type="checkbox"/> Toe/Toes <input type="checkbox"/> Tooth/Teeth (Upper/Lower) <input type="checkbox"/> Wrist(s) (L) (R) <input type="checkbox"/> Other (specify): _____	<input type="checkbox"/> Abrasion <input type="checkbox"/> Allergic Reaction <input type="checkbox"/> Amputation <input type="checkbox"/> Bite <input type="checkbox"/> Blunt Trauma <input type="checkbox"/> Bruise <input type="checkbox"/> Burn <input type="checkbox"/> Chest Pain <input type="checkbox"/> Choking/Suffocation <input type="checkbox"/> Dizziness/Nausea <input type="checkbox"/> Electric Shock <input type="checkbox"/> Exposure <input type="checkbox"/> Food Poisoning <input type="checkbox"/> Foreign Body Eye/Ear <input type="checkbox"/> Fracture <input type="checkbox"/> Head Injury <input type="checkbox"/> Hearing Loss <input type="checkbox"/> Hernia <input type="checkbox"/> Laceration/Cut <input type="checkbox"/> Pain <input type="checkbox"/> Puncture/Stab Wound <input type="checkbox"/> Rash <input type="checkbox"/> Skin Condition <input type="checkbox"/> Slip/Trip/Fall <input type="checkbox"/> Smoke Inhalation <input type="checkbox"/> Strain/Sprain <input type="checkbox"/> Other (specify): _____	<input type="checkbox"/> Bending <input type="checkbox"/> Climbing <input type="checkbox"/> Data Entry <input type="checkbox"/> Driving <input type="checkbox"/> Eating/Drinking <input type="checkbox"/> Entering/Exiting Property <input type="checkbox"/> Entering/Exiting Vehicle <input type="checkbox"/> Jumping <input type="checkbox"/> Kneeling <input type="checkbox"/> Landscaping Function <input type="checkbox"/> Lifting <input type="checkbox"/> Maintenance Activities <input type="checkbox"/> Operating Equipment <input type="checkbox"/> Painting <input type="checkbox"/> Pulling/Pushing <input type="checkbox"/> Reaching <input type="checkbox"/> Rendering Aid <input type="checkbox"/> Repetitive Motion <input type="checkbox"/> Riding on Vehicle <input type="checkbox"/> Running <input type="checkbox"/> Sitting <input type="checkbox"/> Standing <input type="checkbox"/> Sweeping/Raking <input type="checkbox"/> Transporting Materials <input type="checkbox"/> Twisting <input type="checkbox"/> Using Hand Power Tools <input type="checkbox"/> Walking <input type="checkbox"/> Other (specify): _____	<input type="checkbox"/> Animal/Insect <input type="checkbox"/> Assault/Battery <input type="checkbox"/> Blood/Body Fluid <input type="checkbox"/> Broken/Faulty Equipment <input type="checkbox"/> Chemical Agent <input type="checkbox"/> Collapsed Structure <input type="checkbox"/> Dust/Debris <input type="checkbox"/> Electrical Equipment <input type="checkbox"/> Environmental (heat, cold, noise) <input type="checkbox"/> Falling Object <input type="checkbox"/> Fire/Explosion <input type="checkbox"/> Food/Beverage/Medicine <input type="checkbox"/> Infectious Disease <input type="checkbox"/> Medical Condition (if disease) <input type="checkbox"/> Office Equipment/Furniture/Machines <input type="checkbox"/> Personal Contact <input type="checkbox"/> Pulling Object <input type="checkbox"/> Sharp/Blunt Instrument <input type="checkbox"/> Slippery/Wet Surface <input type="checkbox"/> Tools <input type="checkbox"/> Unforeseen Hazards (uneven sidewalks, pavements, broken glass, etc.) <input type="checkbox"/> Vegetation <input type="checkbox"/> Vehicular Accident <input type="checkbox"/> Weapon <input type="checkbox"/> Other (specify): _____ List action(s) needed to prevent reoccurrence: _____	
Did accident/injury require medical attention? <input type="checkbox"/> YES <input type="checkbox"/> NO If yes, name of facility: _____ First-aid only? <input type="checkbox"/> YES <input type="checkbox"/> NO				
Did injury result in lost work/hours? <input type="checkbox"/> YES <input type="checkbox"/> NO Was managed care contacted? <input type="checkbox"/> YES <input type="checkbox"/> NO If yes, date: _____ Case #: _____				
Supervisor Name: (print) : _____ Spvs. Sgn.: _____ Tel. #: _____ Date: _____ _____ 20				
Employee Name (print) : _____ Employee Signature: _____ Date: _____ _____ 20				
Departmental Safety Liaison (print) : _____ Safety Liaison Signature: _____ Date: _____ _____ 20				



City of Miami
Solid Waste (AFSCME AFL-CIO-Local 871) - Operations Employees Only
SUPERVISOR'S REPORT OF EMPLOYEE ACCIDENT/INJURY

Instructions: This form must be completed by the supervisor and the claims network must be contacted at 1-877-647-4545 within 24 hours of occurrence.

EMPLOYEE INFORMATION	Name of Injured Employee: (include middle initial)		D.O.B. (MM/DD/YYYY):	
	Home Address:		Social Security #/Employee ID:	
	Telephone: Home: _____ Cellular: _____		Work: _____	
	Shift:	Job Class/Title:		
	Duty Hours:	Date of Employment (MM/DD/YYYY):	Hourly Rate:	Hours per Week:

ACCIDENT/INJURY INFORMATION	Date of Accident/Injury (MM/DD/YYYY):		Time of Accident/Injury: <input type="checkbox"/> AM <input type="checkbox"/> PM	
	Date Accident/Injury Reported (if different from above) (MM/DD/YYYY):	Did accident/injury occur during duty hours? <input type="checkbox"/> YES <input type="checkbox"/> NO	Safety equipment worn at time of injury? <input type="checkbox"/> YES <input type="checkbox"/> NO	
	Previous injuries? <input type="checkbox"/> YES <input type="checkbox"/> NO	Exact Location of Accident/Injury:	Route/Section: <input type="checkbox"/> Trash <input type="checkbox"/> Garbage <input type="checkbox"/> Recycling <input type="checkbox"/> Night/Day Sweeping <input type="checkbox"/> Virginia Key Composting <input type="checkbox"/> Clean-up Program	
	Briefly describe how accident/injury occurred:			
	Please provide any additional details you feel are pertinent to the accident:			
	List the names of any witnesses and contact info (if available):			

(A) Part of Body Injured (If more than one, check all that apply)	(B) Nature of Injury/Illness	(C) Activity Performed at Time of Accident	(D) Sources of Injury/Accident
<input type="checkbox"/> Abdomen <input type="checkbox"/> Ankle(s) (L) (R) <input type="checkbox"/> Arm(s) (L) (R) <input type="checkbox"/> Back <input type="checkbox"/> Breast(s) (L) (R) <input type="checkbox"/> Buttock(s) (L) (R) <input type="checkbox"/> Cheek(s) <input type="checkbox"/> Chest <input type="checkbox"/> Ear(s) (L) (R) <input type="checkbox"/> Elbow(s) (L) (R) <input type="checkbox"/> Exposure (multiple body parts) <input type="checkbox"/> Eye(s) (L) (R) <input type="checkbox"/> Finger(s) (LH)(RH) <input type="checkbox"/> Foot/Feet (L) (R) <input type="checkbox"/> Groin (L) (R) <input type="checkbox"/> Hand(s) (L) (R) <input type="checkbox"/> Head/Neck Area <input type="checkbox"/> Heart <input type="checkbox"/> Hip(s) (L) (R) <input type="checkbox"/> Knee(s) (L) (R) <input type="checkbox"/> Leg(s) (L) (R) <input type="checkbox"/> Lip(s) <input type="checkbox"/> Lung(s) (L) (R) <input type="checkbox"/> Nose <input type="checkbox"/> Shoulder(s) (L) (R) <input type="checkbox"/> Stomach <input type="checkbox"/> Toe/Toes <input type="checkbox"/> Tooth/Teeth (Upper/Lower) <input type="checkbox"/> Wrist(s) (L) (R) <input type="checkbox"/> Other (specify): _____	<input type="checkbox"/> Abrasion <input type="checkbox"/> Allergic Reaction <input type="checkbox"/> Amputation <input type="checkbox"/> Bite <input type="checkbox"/> Blunt Trauma <input type="checkbox"/> Bruise <input type="checkbox"/> Burn <input type="checkbox"/> Chest Pain <input type="checkbox"/> Choking/Suffocation <input type="checkbox"/> Concussion <input type="checkbox"/> Dizziness/Nausea <input type="checkbox"/> Electric Shock <input type="checkbox"/> Exposure <input type="checkbox"/> Food Poisoning <input type="checkbox"/> Foreign Body Eye/Ear <input type="checkbox"/> Fracture <input type="checkbox"/> Head Injury <input type="checkbox"/> Hearing Loss <input type="checkbox"/> Hernia <input type="checkbox"/> Laceration/Cut <input type="checkbox"/> Pain <input type="checkbox"/> Puncture/Stab Wound <input type="checkbox"/> Rash <input type="checkbox"/> Skin Condition <input type="checkbox"/> Slip/Trip/Fall <input type="checkbox"/> Smoke Inhalation <input type="checkbox"/> Strain/Sprain <input type="checkbox"/> Other (specify) _____	<input type="checkbox"/> Bending <input type="checkbox"/> Climbing <input type="checkbox"/> Data Entry <input type="checkbox"/> Driving <input type="checkbox"/> Eating/Drinking <input type="checkbox"/> Entering/Exiting Property <input type="checkbox"/> Entering/Exiting Vehicle <input type="checkbox"/> Jumping <input type="checkbox"/> Kneeling <input type="checkbox"/> Lifting <input type="checkbox"/> Maintenance Activities <input type="checkbox"/> Operating Equipment <input type="checkbox"/> Pulling/Pushing <input type="checkbox"/> Reaching <input type="checkbox"/> Repetitive Motion <input type="checkbox"/> Riding on Vehicle <input type="checkbox"/> Running <input type="checkbox"/> Sitting <input type="checkbox"/> Standing <input type="checkbox"/> Sweeping/Raking <input type="checkbox"/> Transporting Materials <input type="checkbox"/> Twisting <input type="checkbox"/> Using Hand Power Tools <input type="checkbox"/> Walking <input type="checkbox"/> Other (specify): _____	<input type="checkbox"/> Animal/Insect <input type="checkbox"/> Assault/Battery <input type="checkbox"/> Blood/Body Fluid <input type="checkbox"/> Broken/Faulty Equipment <input type="checkbox"/> Chemical Agent <input type="checkbox"/> Collapsed Structure <input type="checkbox"/> Dust/Debris <input type="checkbox"/> Electrical Equipment <input type="checkbox"/> Environmental (heat, cold, noise) <input type="checkbox"/> Falling Object <input type="checkbox"/> Fire/Explosion <input type="checkbox"/> Food/Beverage/Medicine <input type="checkbox"/> Infectious Disease <input type="checkbox"/> Medical Condition <input type="checkbox"/> Office Equipment/Furniture/Machines <input type="checkbox"/> Personal Contact <input type="checkbox"/> Pulling Object <input type="checkbox"/> Sharp/Blunt Instrument <input type="checkbox"/> Slippery/Wet Surface <input type="checkbox"/> Tools <input type="checkbox"/> Unforeseen Hazards (uneven sidewalks, pavements, broken glass, etc.) <input type="checkbox"/> Vegetation <input type="checkbox"/> Vehicular Accident <input type="checkbox"/> Weapon <input type="checkbox"/> Other (specify): _____ List action(s) needed to prevent reoccurrence: _____

Did accident/injury require medical attention? YES NO If yes, name of facility: _____ First-aid only? YES NO

Did injury result in lost work/hours? YES NO Was managed care contacted? YES NO If yes, date: _____ Case #: _____

Supervisor Name: (print) : _____ Spvs. Sgn.: _____ Tel. #: _____ Date: ____/____/20__

Employee Name (print) : _____ Employee Signature: _____ Date: ____/____/20__

Departmental Safety Liaison (print) : _____ Safety Liaison Signature: _____ Date: ____/____/20__



City of Miami
General Services Administration - Operations Employees Only
SUPERVISOR'S REPORT OF EMPLOYEE ACCIDENT/INJURY

Instructions: This form must be completed by the supervisor and the claims network must be contacted at 1-877-647-4545 within 24 hours of occurrence.

EMPLOYEE INFORMATION	Name of Injured Employee: (include middle initial)		D.O.B. (MM/DD/YYYY):	
	Home Address:		Social Security #/Employee ID:	
	Telephone: Home: _____ Cellular: _____		Work: _____	
	Job Class/Title:		Shift:	
	Duty Hours:	Date of Employment (MM/DD/YYYY):	Hourly Rate:	Hours per Week:

ACCIDENT/INJURY INFORMATION	Date of Accident/Injury (MM/DD/YYYY):		Time of Accident/Injury: <input type="checkbox"/> AM <input type="checkbox"/> PM	
	Date Accident/Injury Reported (if different from above) (MM/DD/YYYY):	Did accident/injury occur during duty hours? <input type="checkbox"/> YES <input type="checkbox"/> NO	Safety equipment worn at time of injury? <input type="checkbox"/> YES <input type="checkbox"/> NO	Status: <input type="checkbox"/> TEMP <input type="checkbox"/> PERM
	Previous injuries? <input type="checkbox"/> YES <input type="checkbox"/> NO	Exact Location of Accident/Injury:		
	Briefly describe how accident/injury occurred:			
	Please provide any additional details you feel are pertinent to the accident:			
	List the names of any witnesses and contact info (if available):			

(A) Part of Body Injured (If more than one, check all that apply)	(B) Nature of Injury/Illness	(C) Activity Performed at Time of Accident	(D) Sources of Injury/Accident
<input type="checkbox"/> Abdomen <input type="checkbox"/> Ankle(s) (L) (R) <input type="checkbox"/> Arm(s) (L) (R) <input type="checkbox"/> Back <input type="checkbox"/> Breast(s) (L) (R) <input type="checkbox"/> Buttock(s) (L) (R) <input type="checkbox"/> Cheek(s) <input type="checkbox"/> Chest <input type="checkbox"/> Ear(s) (L) (R) <input type="checkbox"/> Elbow(s) (L) (R) <input type="checkbox"/> Eye(s) (L) (R) <input type="checkbox"/> Finger(s) (LH)(RH) <input type="checkbox"/> Foot/Feet (L) (R) <input type="checkbox"/> Groin (L) (R) <input type="checkbox"/> Hand(s) (L) (R) <input type="checkbox"/> Head/Neck Area <input type="checkbox"/> Heart <input type="checkbox"/> Hip(s) (L) (R) <input type="checkbox"/> Knee(s) (L) (R) <input type="checkbox"/> Leg(s) (L) (R) <input type="checkbox"/> Lip(s) <input type="checkbox"/> Lung(s) (L) (R) <input type="checkbox"/> Nose <input type="checkbox"/> Shoulder(s) (L) (R) <input type="checkbox"/> Stomach <input type="checkbox"/> Toe/Toes <input type="checkbox"/> Tooth/Teeth (Upper/Lower) <input type="checkbox"/> Wrist(s) (L) (R) <input type="checkbox"/> Other (specify): _____	<input type="checkbox"/> Abrasion <input type="checkbox"/> Allergic Reaction <input type="checkbox"/> Amputation <input type="checkbox"/> Bite <input type="checkbox"/> Blunt Trauma <input type="checkbox"/> Bruise <input type="checkbox"/> Burn <input type="checkbox"/> Chest Pain <input type="checkbox"/> Choking/Suffocation <input type="checkbox"/> Dizziness/Nausea <input type="checkbox"/> Electric Shock <input type="checkbox"/> Exposure <input type="checkbox"/> Food Poisoning <input type="checkbox"/> Foreign Body Eye/Ear <input type="checkbox"/> Fracture <input type="checkbox"/> Head Injury <input type="checkbox"/> Hearing Loss <input type="checkbox"/> Hernia <input type="checkbox"/> Laceration/Cut <input type="checkbox"/> Pain <input type="checkbox"/> Puncture/Stub Wound <input type="checkbox"/> Rash <input type="checkbox"/> Skin Condition <input type="checkbox"/> Slip/Trip/Fall <input type="checkbox"/> Smoke Inhalation <input type="checkbox"/> Strain/Sprain <input type="checkbox"/> Other (specify): _____	<input type="checkbox"/> Bending <input type="checkbox"/> Climbing <input type="checkbox"/> Data Entry <input type="checkbox"/> Digging <input type="checkbox"/> Driving <input type="checkbox"/> Eating/Drinking <input type="checkbox"/> Entering/Exiting Property <input type="checkbox"/> Entering/Exiting Vehicle <input type="checkbox"/> Fuel Dispensing Operation <input type="checkbox"/> Jumping <input type="checkbox"/> Kneeling <input type="checkbox"/> Landscaping Functions <input type="checkbox"/> Lifting/Loading <input type="checkbox"/> Maintenance Repair <input type="checkbox"/> Operating Equipment/Machinery <input type="checkbox"/> Painting <input type="checkbox"/> Pulling/Pushing <input type="checkbox"/> Reaching <input type="checkbox"/> Repetitive Motion <input type="checkbox"/> Riding on Vehicle <input type="checkbox"/> Running <input type="checkbox"/> Sitting <input type="checkbox"/> Standing <input type="checkbox"/> Sweeping/Raking <input type="checkbox"/> Transporting Materials <input type="checkbox"/> Twisting <input type="checkbox"/> Using Handpower Tools <input type="checkbox"/> Vehicle repair activities <input type="checkbox"/> Walking <input type="checkbox"/> Welding <input type="checkbox"/> Other (specify): _____	<input type="checkbox"/> Animal/Insect <input type="checkbox"/> Assault/Battery <input type="checkbox"/> Blood/Body Fluid <input type="checkbox"/> Broken/Faulty Equipment <input type="checkbox"/> Chemical Agent <input type="checkbox"/> Collapsed Structure <input type="checkbox"/> Dust/Debris <input type="checkbox"/> Electrical Equipment <input type="checkbox"/> Environmental (heat, cold, noise) <input type="checkbox"/> Falling Object <input type="checkbox"/> Fire/Explosion <input type="checkbox"/> Food/Beverage/Medicine <input type="checkbox"/> Infectious Disease <input type="checkbox"/> Medical Condition <input type="checkbox"/> Office Equipment/Furniture/Machines <input type="checkbox"/> Personal Contact <input type="checkbox"/> Pulling Object <input type="checkbox"/> Sharp/Blunt Instrument <input type="checkbox"/> Slippery/Wet Surface <input type="checkbox"/> Tools <input type="checkbox"/> Unforeseen Hazards (uneven sidewalks, pavements, broken glass, etc). <input type="checkbox"/> Vegetation <input type="checkbox"/> Vehicular Accident <input type="checkbox"/> Weapon <input type="checkbox"/> Other (specify): _____ List action(s) needed to prevent recurrence: _____

Did accident/injury require medical attention? YES NO If yes, name of facility: _____ First-aid only? YES NO

Did injury result in lost work/hours? YES NO Was managed care contacted? YES NO If yes, date: _____ Case #: _____

Supervisor Name: (print): _____ Spvs. Sgn.: _____ Tel. #: _____ Date: _____ | _____ | 20__

Employee Name (print): _____ Employee Signature: _____ Date: _____ | _____ | 20__

Departmental Safety Liaison (print): _____ Safety Liaison Signature: _____ Date: _____ | _____ | 20__