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: ❑ AM ❑ PM

Date Accident/Injury Reported (if different from above) (MM/DD/YYYY): | Did accident/injury occur during duty hours? ❑ YES ❑ NO | Safety equipment worn at time of injury? ❑ YES ❑ NO

Previous injuries? ❑ YES ❑ NO | Exact Location of Accident/Injury: | Route/Section: ❑ Trash ❑ Garbage ❑ Recycling ❑ Night/Day Sweeping ❑ Virginia Key Composting ❑ 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):

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

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

### (A) Part of Body Injured
(If more than one, check all that apply)

- ❑ Abdomen
- ❑ Ankle(s) (L) (R)
- ❑ Arm(s) (L) (R)
- ❑ Back
- ❑ Breast(s) (L) (R)
- ❑ Buttock(s) (L) (R)
- ❑ Cheek(s)
- ❑ Chest
- ❑ Ear(s) (L) (R)
- ❑ Elbow(s) (L) (R)
- ❑ Exposure (multiple body parts)
- ❑ Eye(s) (L) (R)
- ❑ Finger(s) (LH)(RH)
- ❑ Foot/Feet (L) (R)
- ❑ Groin (L) (R)
- ❑ Hand(s) (L) (R)
- ❑ Head/Neck Area
- ❑ Heart
- ❑ Hip(s) (L) (R)
- ❑ Knee(s) (L) (R)
- ❑ Leg(s) (L) (R)
- ❑ Lip(s)
- ❑ Lung(s) (L) (R)
- ❑ Nose
- ❑ Shoulder(s) (L) (R)
- ❑ Stomach
- ❑ Toe/Toes
- ❑ Tooth/Teeth (Upper/Lower)
- ❑ Wrist(s) (L) (R)
- ❑ Other (specify): _____

### (B) Nature of Injury/Illness

- ❑ Abrasion
- ❑ Allergic Reaction
- ❑ Amputation
- ❑ Bite
- ❑ Blunt Trauma
- ❑ Bruise
- ❑ Burn
- ❑ Chest Pain
- ❑ Choking/Suffocation
- ❑ Concussion
- ❑ Dizziness/Nausea
- ❑ Electric Shock
- ❑ Exposure
- ❑ Food Poisoning
- ❑ Foreign Body Eye/Ear
- ❑ Fracture
- ❑ Head Injury
- ❑ Hearing Loss
- ❑ Hernia
- ❑ Laceration/Cut
- ❑ Pain
- ❑ Puncture/Stab Wound
- ❑ Rash
- ❑ Skin Condition
- ❑ Slip/Trip/Fall
- ❑ Smoke Inhalation
- ❑ Strain/Sprain
- ❑ Other (specify) _____

### (C) Activity Performed at Time of Accident

- ❑ Bending
- ❑ Climbing
- ❑ Data Entry
- ❑ Driving
- ❑ Eating/Drinking
- ❑ Entering/Exiting Property
- ❑ Entering/Exiting Vehicle
- ❑ Jumping
- ❑ Kneeling
- ❑ Lifting
- ❑ Maintenance Activities
- ❑ Operating Equipment
- ❑ Pulling/Pushing
- ❑ Reaching
- ❑ Repetitive Motion
- ❑ Riding on Vehicle
- ❑ Running
- ❑ Sitting
- ❑ Standing
- ❑ Sweeping/Raking
- ❑ Transporting Materials
- ❑ Twisting
- ❑ Using Hand Power Tools
- ❑ Walking
- ❑ Other (specify): _____

### (D) Sources of Injury/Accident

- ❑ Animal/Insect
- ❑ Assault/Battery
- ❑ Blood/Body Fluid
- ❑ Broken/Faulty Equipment
- ❑ Chemical Agent
- ❑ Collapsed Structure
- ❑ Dust/Debris
- ❑ Electrical Equipment
- ❑ Environmental (heat, cold, noise)
- ❑ Falling Object
- ❑ Fire/Explosion
- ❑ Food/Beverage/Medicine
- ❑ Infectious Disease
- ❑ Medical Condition
- ❑ Office Equipment/Furniture/Machines
- ❑ Personal Contact
- ❑ Pulling Object
- ❑ Sharp/Blunt Instrument
- ❑ Slippery/Wet Surface
- ❑ Tools
- ❑ Unforeseen Hazards (uneven sidewalks, pavements, broken glass, etc).
- ❑ Vegetation
- ❑ Vehicular Accident
- ❑ Weapon
- ❑ 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 accident reported to network phone number above? ❑ 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____



**Distribution: White** - Dept. Employee File; **Canary** - Safety Officer (Risk Management); **Pink** - Risk Management.