



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

(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 Was accident reported to network phone number above? 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____