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:	❏ 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	Status: ❏ TEMP ❏ PERM

Previous injuries? ❏ YES ❏ 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 (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
❏ 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) ❏ 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): _____	❏ Abrasion ❏ Allergic Reaction ❏ Amputation ❏ Bite ❏ Blunt Trauma ❏ Bruise ❏ Burn ❏ Chest Pain ❏ Choking/Suffocation ❏ Dizziness/Nausea ❏ Electric Shock ❏ Exposure ❏ Food Poisoning ❏ Foreign Body Eye/Ear ❏ Fracture ❏ Head Injury ❏ Hearing Loss ❏ Hernia ❏ Laceration/Cut ❏ Pain ❏ Puncture/Stab Wound ❏ Skin Condition ❏ Slip/Trip/Fall ❏ Smoke Inhalation ❏ Strain/Sprain ❏ Vision Loss ❏ Other (specify) _____	❏ Bending ❏ Climbing ❏ Data Entry ❏ Driving ❏ Eating/Drinking ❏ Entering/Exiting Property ❏ Entering/Exiting Vehicle ❏ Jumping ❏ Kneeling ❏ Lifting ❏ Operating Equipment ❏ Pulling/Pushing ❏ Reaching ❏ Repetitive Motion ❏ Riding on Vehicle ❏ Running ❏ Sitting ❏ Standing ❏ Sweeping/Raking ❏ Twisting ❏ Walking ❏ Other (specify): _____	❏ 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 ❏ 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