

Incident Report Form

Submit to MACC's Benefits Team, MCW Human Resources Dept, via fax (612-341-1653) or e-mail (benefits@mcwmn.org) within 24 hours of incident. The Benefits Team can be reached by phone at (612)341-1627 or (612)341-1614.

Agency: _____

Date of Incident:	Time of Incident: AM/PM	Type of Incident (check all that apply): <input type="checkbox"/> Employee Injury <input type="checkbox"/> Auto Accident <input type="checkbox"/> Property Damage <input type="checkbox"/> Participant Injury <input type="checkbox"/> Theft <input type="checkbox"/> Other	
Your name:		SSN:	Birthdate:
Your Address:		City:	State, Zip
Home Phone:	Did the incident occur on Agency property? <input type="checkbox"/> Yes <input type="checkbox"/> No	Location where Incident Occurred:	
Work Phone:	Was an Agency vehicle involved? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Name of Injured Employee or Participant:			

Briefly describe the incident:

How were you involved in the incident? (injured employee, witness)

Was anyone else involved? (please provide names and contact info, if available)

Were there any other witnesses? (please provide names and contact info, if available)

Was this incident reported to the police? Yes No Police Report #

Did the incident occur indoors or outdoors?

What were the conditions of the area where the incident occurred? (wet floor, icy sidewalk, bad weather, etc)

- | | | | |
|-------------------------------------------------------------------------------|------------------------------|-----------------------------|------------------------------|
| Was the injured person properly instructed in safe & efficient methods? | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> N/A |
| Did the injured person violate any instructions or safety policies? | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> N/A |
| Was necessary protective equipment worn (eye protection, seatbelt)? | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> N/A |
| Did poor housekeeping (debris, items not stored properly) contribute? | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> N/A |
| Was the equipment/tool in good working condition? | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> N/A |
| Was the accident caused by an unsafe act (i.e., horseplay, driving too fast)? | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> N/A |
| Is there any risk of a repeat incident? | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> N/A |

Briefly explain any Yes answers to above questions

Please complete the following for employee or participant injuries only.

What part of the body was injured?

Have you ever been injured there before? Yes No If Yes, when?

What follow-up actions were taken (first aid, doctor/clinic visit, emergency room?)

Name, address & phone # of hospital, clinic or doctor:

(Please attach copies of any doctor's statements you have received)

Please complete the following for thefts of property only:

Please list the items stolen:

Where were the items stolen from? (office, storage room, etc)

Were the items stolen agency property or personal property?

Please complete the following for property damage only:

Briefly describe the damage (broken window in office, graffiti on building, etc)

Was the damage the result of a natural disaster? (fallen tree, wind damage, etc)

Please complete the following for vehicle accidents only:

Was the vehicle involved agency-owned or personal?

Was anyone else in the vehicle injured? Please provide name, contact info and brief description of injuries:

Please list the names and contact info for any other passengers in the vehicle:

Were any other vehicles involved in the accident? Yes No If Yes, please provide name and contact info for other driver(s):

Employee Signature _____ Date _____

Director or VP Signature _____ Date _____