Montgomery County Report of Injury Form

Name:______________________________ **Sex:** **M** ☐ **F** ☐ **Marital Status:** ☐ **Single** ☐ **Married**

DOB: ________________ **Race:** ____________ **SSN:** ________________________

Address: ____ **Phone:** ________________

Department: ________________________ **Job title:**__________________________ **Hourly Rate:** __________

Work Phone: ________________________ **Supervisor:** ____

Date of Incident: **Date Reported:** **Time Reported:**

Name of physician chosen (from Panel):

Witnesses: #1 Name: ______________________ **Address:** ____________________________ **Phone:** __________

#2 Name: **Address:** **Phone:**

Length of Employment:
- ☐ **Less than 1 month**
- ☐ **1-5 months**
- ☐ **6 mos. To 5 yrs.**
- ☐ **More than 5 yrs.**

Accident Location:

____

____

____

On Employer's Premises:
- ☐ **YES**
- ☐ **NO**

Job Classification:

Full Time ☐ Temporary ☐

Part Time ☐ Seasonal ☐

Time of the injury:

A. ___:_____AM ___:____PM

B. Time Within Shift ______th hour

C. ☐ straight shift ☐ rotating shift

D. ☐ 1st Shift ☐ 2nd Shift ☐ 3rd Shift

Shift Begin Time ________

Shift End Time ________

Severity of Injury
- ❑ Fatality
- ❑ Lost Workdays
- ❑ Restricted Activity
- ❑ Medical Treatment
- ❑ First Aid
- ❑ Other:_________________________

Phase of Employee's Workday at Time of Injury:
- ❑ During rest period
- ❑ During meal period
- ❑ Working overtime
- ❑ Entering or leaving workplace
- ❑ Performing work duties
- ❑ Other:__________________________________

Task and Activity at time of accident:

General Task:_____________________________________

____

Specific Activity:__________________________________

____

Supervision at time of Accident:
- ❑ Directly Supervised
- ❑ Indirectly Supervised
- ❑ Not supervised

Employee Was Working:
- ❑ Alone
- ❑ With others
- ❑ Other:________________________

Type of injury: ____________________________ **Body Part** ________________________________

What caused the injury? ____

Were safety requirements followed? ____

Equipment Used ☐ Safety Glasses ☐ Respirator ☐ Hard Hat ☐ Safety Shoes ☐ Gloves

☐ Body Harness ☐ Safety Vest ☐ Other ____________________

What happened and list steps taken to prevent reoccurrence:

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I understand and agree that if benefits are paid by Montgomery County Government for an on the job injury , and the injury was due to the actions of a third party, the county has a right to a claim against the third party for the reimbursement of those benefits only. This in no way prohibits the employee from any recovery as a result of an injury inflicted by a third party to which he or she is legally entitled. I also acknowledge the information contained on this form is true and correct to the best of my ability.

Employee Signature:______________________________ **Date**______________________

Prepared by:	**Approved by:**
Supervisor:______________________________	**Department Head:** ______________________
Print Name	**Print Name**
______________________________	______________________________
Signature	**Signature**
Title: ______________________________	**Title:**______________________________
Date:__________	**Date:**__________

Additional information to be considered:

Yellow – Supervisor Blue – Employee Green – Witness Pink – Department Head