CITY OF EL PASO
Supervisor's Report of Accident, Injury, Or Occupational Illness

Department: _____ Division: _____
Date of Incident: ___/__/____ Reported To: _____
Date Reported:___/__/_____ Time Reported: _____

Name: (First) _____ (Initial) _____ (Last) _____
SSN: _____-_____-_____ Sex: __ DOB: ___/__/____ Date of Hire: ___/___/_____
Job Classification: _____ Time in Classification: _____

Type of Incident ☐ Injury ☐ Occupational Illness ☐ Non-Injury Incident ☐ Exposure Incident
Informational Only

Location of Incident (Address, shop. etc.) _____
Specific Location (front yard, bay #2, etc.) _____

Time Occurred: _____ ☐ AM ☐PM Day of Week: _____
Worked Remainder of Shift: ☐ Yes ☐ No Time Shift Started: _____ ☐ AM ☐PM
Employee was: ☐ Alone ☐ With Co-Worker Who: _____
Supervision at Time of Incident: ☐ Directly Supervised ☐ Indirectly Supervised ☐ Not Supervised
Specific Activity When Incident Occurred: _____
Was this a Normal Duty: ☐ Yes ☐ No Was Proper PPE Available: ☐ Yes ☐ No
Was PPE Used? ☐ Yes ☐ No

Describe What Happened: _____
_____
_____
Nature of Injury/Illness/Exposure: _____

Severity: ☐ First Aid Only ☐Medical Treatment _____
☐Refused Medical Treatment ☐Referred to Infectious Disease Control Nurse
☐Fatality
☐No Lost Time ☐Losing Time Now Time Lost to Date: _____

Property Damage: ☐ Yes ☐ No Type: _____
Vehicle Involved: ☐ Yes ☐ No Description: _____
Seat Belts Worn: ☐ Yes ☐ No

How can a similar incident be prevented from happening: _____
_____

Print
Supervisor: _____ Title: _____ Date: _____
Name

Supervisor Signature:_____
***(required)***

Dept. Head Signature: _____ Date: _____

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