VOLUNTEER INCIDENT REPORT (FOR REPORTING WORK-RELATED INJURIES & ILLNESSES)

Volunteers must complete this Incident Report when they sustain a work-related injury or illness. Please complete and return it to your supervisor immediately.

Incident Reporting ensures there is a record of the incident on file and helps the County of Alameda provide a safe work environment.

In filing this Incident Report you are not filing a workers' compensation claim.

The County will provide "First-Aid' treatment which may include any initial visit to the medical provider, minor treatment and diagnostics, and follow-up visit.

If your physician indicates that your injury requires medical treatment beyond first-aid or certifies disability beyond your work-shift at the time of injury, you will need to seek treatment through your personal health insurance plan.

VOLUNTEER NAME (PLEASE PRINT)	LAST 4 DIGITS OF SSN	WORK PHONE	HOME PHONE

HOME STREET ADDRESS

CITY, STATE, ZIP CODE	OCCUPATION/JOB TITLE

DEPARTMENT NAME	SUPERVISOR NAME (PLEASE PRINT)	SUPERVISOR PHONE

DO YOU HAVE OTHER EMPLOYMENT?	IF YES, WHERE?

DATE OF INCIDENT	TIME OF INCIDENT	TIME BEGAN WORK	TIME STOPPED WORK	FINISHED SHIFT? ☐ YES ☐ NO

LOCATION OF INCIDENT (ADDRESS, BUILDING NAME, ROOM NUMBER, CITY, STATE, ZIP):	ON COA PROPERTY? ☐ YES ☐ NO

HOW DID THE INCIDENT OCCUR? DESCRIBE THE ACTIVITY AND ANY TOOLS, EQUIPMENT, OR MATERIAL YOUR WERE USING (Example: I was opening a box of paper using an exacto-knife. The exacto-knife slipped on the surface of the box, and cut the skin of my right index finger):

LIST THE BODY PART(S) INJURED AND TYPE OF INJURY (Example: Skin cut on right index finger.):

HOW DO YOU THINK THIS TYPE OF INCIDENT CAN BE PREVENTED? (Example: By wearing protective gloves while using exacto-knife.):

INCIDENT REPORTED? ☐ YES ☐ NO	IF YES, TO WHOM DID YOU REPORT IT?	DATE REPORTED

WITNESSES? ☐ YES ☐ NO	IF YES, WITNESS #1 (NAME & PHONE)	WITNESS #2 (NAME & PHONE)

IS THIS A NEW INJURY? ☐ YES ☐ NO	IF NO, PLEASE DESCRIBE THE ORIGINAL INJURY:	DATE OF ORIGINAL INJURY

DID YOU RECEIVE TREATMENT?

☐ Reporting Only (No Treatment Needed) ☐ I declined treatment at the time ☐ Treatment was provided ☐ Treatment will be provided or sought

IF YOU RECEIVED TREATMENT, WHO PROVIDED IT?

PROVIDER NAME	ADDRESS	PHONE

DESCRIBE THE TREATMENT PROVIDED (Example: Cut was washed; antiseptic and bandage were applied.):

DID THE PROVIDER CERTIFY YOU FOR DISABILITY BEYOND THE WORK-SHIFT? ☐ YES ☐ NO If certified for disability beyond the work-shift please attach a copy of the certification	HAS THE PROVIDER RELEASED YOU FROM CARE? ☐ YES: Released ☐ NO: I will return for follow-up

By signing this form, the volunteer certifies that the information provided is true to the best of the volunteer's knowledge.	VOLUNTEER SIGNATURE	DATE SIGNED

RETURN FORM TO: SUPERVISOR

Rev. 04/30/13