City of Bellaire

ACCIDENT/INCIDENT REPORT

To be completed by Supervisor and submitted within 24 hours to:

Employee Injury - Email completed form to: HR@bellairetx.gov

Auto/Liability/Property - Email completed form to: TGross@bellairetx.gov

Check Type:

☐ Workers comp. (Claim), complete Sections 1, 2, 5, 6
☐ Liability Claim, complete Sections 1, 4, 5, 6
☐ Property/Equipment (Claim), complete Sections 1, 3, 4, 5, 6
☐ Motor Vehicle Claim, complete Sections 1, 3, 4, 5, 6

Check Notification:

Notified Police: ☐ Yes ☐ No
Required for all Auto Accidents /Property Damage

Notified Department Designee: ☐ Yes ☐ No
Required for all Auto Accidents /Property Damage

Notified HR: ☐ Yes ☐ No
Required for all employee injuries

SECTION 1 BASIC INFORMATION

Employee/Citizen Name:_____ Employee ID Number (if applicable):_____
Department:_____ Date of Incident: _____
Supervisor Name:_____ Time of Incident:_____a.m._____p.m.
Supervisor Phone & Ext.:_____ Time Shift Started:_____a.m._____p.m.
Supervisor Cell Phone:_____ Day of Week: _____
Date Reported to Supervisor:_____
Location/Address of Incident:_____

SECTION 2. WORKERS' COMPENSATION

Employee's Home Address:_____
City:_____ State:_____ Zip:_____ County:_____
Home Phone:_____ Phone# where employee can be reached:_____
Treating Doctor (if known)_____
Clinic/Hospital: _____ Phone: _____
Address:_____ City:_____ State:_____ Zip:_____
Nature of Injury:_____ Cause of Injury: _____
Part of body injured: _____
Employee Refused Medical Treatment: Yes ☐ No ☐ Medical Treatment Received: Yes ☐ No ☐
Was there any loss of time? Yes ☐ No ☐ If yes, date loss of time started: _____

SECTION 3. CITYVEHICLE ACCIDENT/PROPERTY/EQUIPMENT DAMAGE

Describe damage ***Include photos**

Year ☐ Make: ☐ Model: ☐ VIN: ☐ Vehicle #: ☐

Police report Number: ☐ Vehicle Towed: Yes ☐ No ☐

SECTION 4. VEHICLE/PROPERTY DAMAGE (NOT CITY)

Owner of vehicle/property: _____ Driver of Vehicle: _____

Address or Location: _____ Telephone Number: _____

City: _____ State: _____ Zip: _____ County: _____

Year: _____ Make: _____ Model: _____ License Number: _____ VIN: _____

Driver's Insurance Company: _____ Policy Number: _____

SECTION 5 COMPLETE FOR ALL ACCIDENTS/INCIDENTS

Witness Name, Address, Contact Phone: _____

Witness Name, Address, Contact Phone: _____

SECTION 6 SUPERVISOR'S INVESTIGATIONREPORT

What happened? *Describe what took place or what caused you to conduct this investigation.* **Why did it happen?** Get all the facts by studying the job and situation involved. **What have you done thus far?** Take or recommended action, depending upon your authority.

Did the action(s) of another cause/contribute to the incident? ☐ Yes ☐ No If yes, list names:

Was personal protective equipment in use? ☐ Yes ☐ No

Was a seat belt worn? ☐ Yes ☐ No

Was the Accident caused by any of the below factors:

Environmental ☐ Yes ☐ No

Equipment: ☐ Yes ☐ No

Operator: ☐ Yes ☐ No

Weather: ☐ Yes ☐ No

Attach photos if applicable. Attach police report if applicable.

Alcohol & Controlled Substance Policy: Employee Drug Screen: Yes ☐ No ☐

Employee's signature: _____ Date: _____

Supervisor's signature: _____ Date _____

Employee Injury - Email completed form to: HR@bellairetx.gov

Auto/Liability/Property - Email completed form to: TGross@bellairetx.gov

Questions: On the job injury please contact (713) 662-8104

Questions: Auto/Liability/Property please contact (713) 662-8138