CITY OF MARGATE
Together We Make It Great

Department of Human Resources – Risk Management

Workers Compensation Incident Report

Employee Incident Report

Name of injured employee:	Job Title:	
Date and time of incident:	Department:	Date last worked:
Date supervisor notified:	Name of supervisor notified:	

Vehicle Involved: ☐ No ☐ Yes Vehicle ID Number: _____

Police Report: ☐ No ☐ Yes Police Report Number: _____

Photos: ☐ No ☐ Yes If yes, please attach.

Address/Site where the incident occurred (please be specific):

Briefly describe the circumstances and cause of the incident:

Describe the specifics of the injury/illness:

I was involved in an incident and I ☐ did ☐ did not require medical treatment.

(Loss of duty is defined by loss of one full shift as determined by an authorized treating provider)

I was involved in an incident that ☐ did ☐ did not result in loss of duty.

I understand that if I have sustained an injury/illness due to this accident/incident, then I am required to report it immediately to my supervisor. I understand that I have the option to seek treatment at MD Now or the nearest hospital and report a claim through Workers Compensation. I understand that if I decline medical treatment then I have two years from the date of injury or illness to file a claim for Workers Compensation benefits in accordance with F.S 440.19.

Employee Signature: _____ Date: _____

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Supervisor's Incident Investigation Form

Describe in detail what happened:

Why did the incident occur?

Was the employee trained to perform this job task? Yes ☐ No ☐ N/A ☐

Does a standard operating procedure (SOP) or general order (GO) exist for the above described action?

Yes ☐ No ☐

What is the safety procedure for this job?

What will be done in the interim and in the future to prevent this type of incident?

Is it possible that there is a third party responsible for the injuries? Yes ☐ No ☐

Who called the Managed Care Provider FMIT? _____ Title: _____

Date/Time FMIT Contacted: _____

I have discussed this completed report with the employee before turning it into the Department Director and Human Resources.

Supervisor's Signature: _____ Date:_____

Supervisor's Printed Name: _____

Department Director's Signature:_____ Date:_____

HR/FMIT use Only:

Employee Social Security Number: _____ Employee Phone Number: _____

Employee Date of Birth: _____ Normal Hours Worked: _____

Wages: _____

Employee Mailing Address: _____

Note: Please send completed report to the Risk Management Division at MargateRisk@margatefl.com as well as departmental notification requirements.