Location Code: _____	OSHA 300 Log Case No: _____	Claim No: _____ Risk Management Use Only

HOWARD COUNTY
EMPLOYEE INCIDENT/INJURY REPORT

INSTRUCTIONS: This form must be completed immediately for all job-related injuries or infectious material exposures. Please print and answer all questions completely. If you do not understand the questions or need help completing this form, ask your supervisor for assistance. After you have completed Section I, return the form to your supervisor to complete Section II.

Notice of employee injuries must be faxed to Risk Management (410) 313-6399 within 24 hours. Do not delay notification if information is incomplete. Call Risk Management at once if injury is serious (410) 313-6390).

SECTION I - Employee Information:

Dept: _____ Division: _____ Job Title: _____

Full Name: _____ Male/Female Social Security # _____

Date of Birth: _____ Home Phone: _____Work Phone: _____

Home Address: _____
(Include Street, City, State, Zip Code)

Date of Incident: _____ Date Hired: _____ Wage/Salary: $ _____

Time Employee Began Work Day: _____ AM/PM Time of Incident: _____ AM/PM

Location of Incident (Be Specific): _____

Describe in detail what happened. Include work activity being performed and what caused the incident:

_____

_____

_____

_____

Names of persons who witnessed the incident: (If not a County employee, include address and phone #)

Name: _____ Dept: _____ Phone # _____

Name: _____ Dept: _____ Phone # _____

_____

Injured Part of Body and Type of Injury? (List all that apply) _____

_____

When did you report the incident? _____ Who did you report it to? _____

Did you seek medical treatment? Yes / No Where were you treated? _____

EMPLOYEE SIGNATURE: _____ DATE: _____

This form is for Howard County internal use only; it does not constitute filing a claim with the Maryland Workers' Compensation Commission.

(Over)

Section II - Supervisor Information:

Supervisor's Name: _____ **Division:** _____

Job Title: _____ **Phone:** _____ **Fax:** _____

Description of Incident (facts as you know them; do not make assumptions): _____

_____

_____

_____

List all witnesses, in addition to those listed in Section I: _____

_____

When were you informed of the incident: _____

How were you informed: _____

Was the incident the result of defective equipment or the action of non-county employees? (Please describe, preserve evidence and take photographs) _____

_____

_____

Please list what object or substance directly harmed the employee and the corrective action to prevent further incidents and expected completion dates: _____

_____

_____

What safety procedures or personal protective equipment were not in use at time of incident?

_____

_____

Has employee returned to work? Yes / No If so, when? _____

Was there any lost time from work? Yes / No If so, how long? _____

If the employee died, when did death occur? _____

SUPERVISOR'S SIGNATURE: _____ **DATE:** _____

Fax this form immediately to Risk Management (410-313-6399). Serious injuries must be called in at 410-313-6390. Email risk@howardcountymd.gov Send original to Risk Management: 6751 Columbia Gateway Drive, Columbia, MD, 21046. Keep a copy for Department file.

Form RM-1
Revised (2/16)