SAFETY COMMITTEE ACCIDENT REPORT
CITY OF FONTANA

Date: ____________________

To be completed within 24 hours after accident by Supervisor and forwarded to Risk Management.

Name of involved party: ______________________________ Dept: ___________________

Accident Date: ___________________________ Time of Accident: _______ AM _____ PM

Accident Location: ____

Describe how accident occurred *(add more pages if necessary, include diagram)*

Name(s) of witness(es): ____

Injuries: Yes ____ No ____ If yes, describe injury: ________________________________

____

Was Doctor's attention required?: Yes ____ No ____ If yes, name and address of doctor:
____

Was the injured party hospitalized? Yes ____ No ___
If yes, name of hospital: __________________

Has subject party been involved in previous accidents while employed by the City of Fontana during the past three years? Yes ____ No ____ If yes, specify dates and type of accidents:

What steps have been taken to prevent similar accidents?

Suggestions by employee for prevention of similar type accident?

Supervisor Signature:____________________ Employee Signature: ______________________

Findings and dispositions by safety committee at meeting held: Yes ___ No ____