On The Job Injury Report
City of Clarksville

NOTICE: *The On-the-Job Injury Policy requires all injuries and accidents to be reported to your supervisor no later than one (1) hour from the time of injury. You are responsible to notify your supervisor and having this form is completed. Failure to follow the requirements of the OJI program may result in your injury not being covered by the City.*

EMPLOYEE INFORMATION

Department	Job Title	Injury Date/Time	Time you started work	Immediate Supervisor

Name	Date of Birth	Age	Gender ☐ Male ☐ Female	Date of Hire

Home Address	City	State	Zip	Cell Phone

Is the City insurance your primary health insurance? ☐ Yes ☐ No	Are you Medicare eligible? ☐ Yes ☐ No	If Medicare eligible, what are your specific benefits *(disability, etc.)*?	

Safety equipment used at time of injury:
☐ Safety Glasses ☐ Safety Shoes ☐ Respirator ☐ Gloves ☐ Fall Protection ☐ Hard Hat ☐ Seat Belt ☐ Traffic Vest

I understand and agree that if benefits are paid by the City of Clarksville for an on the job injury, and the injury was due to the actions of a third party, the city has a right to a claim against the third party for the reimbursement of those benefits only. This in no way prohibits the employee from any recovery as a result of an injury inflicted by a third party to which he or she is legally entitled. If I have received medical treatment from a physician or medical facility other than a city-authorized physician for this injury, I hereby grant the treating physician permission to release any or all medical records related to this injury to the City. I further acknowledge the information contained on this form is true and correct to the best of my ability.

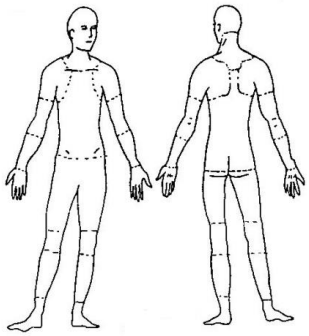
Employee Signature: **Date:**

EMPLOYEE'S SUPERVISOR MUST COMPLETE BELOW

INJURY INFORMATION

Date and time notified:	How were you notified? ☐ Phone ☐ Radio ☐ In person	Accident location/address:

Describe Injury (example: one inch cut to left leg)	Body Part:	Side of Body: ☐ Left ☐ Right
	Shade part of body affected:	Nature of injury: (most serious one)



Nature of injury: (most serious one)
☐ Abrasions, cuts, scrapes
☐ Amputation
☐ Broken bone
☐ Bruise
☐ Burn
☐ Crushing Injury
☐ Cut, laceration, puncture
☐ Job-related Illness
☐ Sprain, strain
☐ Exposure to environment
☐ Exposure to substance
☐ Existing injury (document below)

☐ Other:

What happened?
(ie: slipped and fell on wet rock while walking to car)

When did injury happen:
☐ Entering or leaving work
☐ During normal work activity
☐ During meal period or break
☐ During unusual work activity
☐ Working overtime
☐ Other

Did Injury Require Medical Treatment? ☐ Yes ☐ No	Name of doctor or clinic visited

What was the employee doing just before the injury occurred? (Use back of page if needed)

What Steps Are Being Taken To Prevent A Similar Injury?	List names of witnesses:

Was the employee treated in an Emergency Room?	Was the employee hospitalized overnight as an inpatient?

Had Employee Been Trained? ☐ Yes ☐ No	Was Injury Reported When It Occurred? ☐ Yes ☐ No	Was Safety Coordinator or HR Notified? ☐ Yes ☐ No Date / Time:

REVIEW

Report Prepared By	Signature	Date

Supervisor Reviewing Report	Signature	Date

Department Head	Signature	Date

HR

Risk Management	**Medicare contacted** ☐ Yes ☐ No	**Medicare Notification Confirmation #**	**Other**