

Work Release Accident/Incident Report

(To be completed by the employer and submitted to the facility head)

Incident Date: _____ Incident Time: _____

Inmate Name: _____ Inmate DOC Number: _____

Facility: _____ Date of Employment: _____

Employer: _____

Address: _____ Phone Number: _____

Describe specifically what happened leading up to and when the injury occurred. Include any tools, equipment, structures, or fixtures involved in the accident/incident.

Type and location of injury on the body: (Be Specific)

Work location where injury occurred: (Be Specific)

Did Injury require transport to medical clinic/hospital?

Name, Address, Telephone Number of Clinic/Hospital:

Method of transportation to clinic/hospital:

Date accident/incident Workers' Compensation claim filed?

Name of workplace supervisor at the time of accident/incident? _____

What was the date of the inmate's training/orientation? _____

Date of last urinalysis test conducted by employer or facility: _____

Test(s) Conducted (circle all that apply): Meth AMP PCP COC THC Opiates Alcohol BARB BENZ

Results (Indicate any positive results. If all tests are negative, please record negative): _____

Were the appropriate personal protective equipment or safety measures being used and what were the measures being used.? If not, please explain. _____

Report prepared by: _____ Date: _____

Facility Safety Officer Review: _____ Date: _____

Facility Head Review: _____ Date: _____

Division Review: _____ Date: _____