

# City of East Point Supervisor's Accident Report

(To be completed immediately after accident/illness/loss being discovered)

Type of Accident/Loss:     Injury     Vehicle Accident     Occ. Illness     Property Damage  
                                   Fire/Loss     Theft     Other Loss/Liability

Case #: \_\_\_\_\_ Employee Phone #: \_\_\_\_\_  
Date Occurred: \_\_\_\_\_ Time: \_\_\_\_\_  a.m.     p.m.  
Employee Name: \_\_\_\_\_ DOH \_\_\_\_\_ Hr. Salary \_\_\_\_\_  
SSN: \_\_\_\_\_ Age: \_\_\_\_\_ DOB: \_\_\_\_\_ Marital Status: \_\_\_\_\_ Sex: \_\_\_\_\_  
Employee Address: \_\_\_\_\_ City/State/Zip \_\_\_\_\_

Administrative/Mgt.     Electric     Public Works     Sanitation     Garage  
 Building/Grounds     Water Treatment     Fire     Police     Parks/Rec.  
 Administrative Services     Community Services     Other, State: \_\_\_\_\_

Nature of Injury/Illness: \_\_\_\_\_  
(Strain, Laceration, Burn, Fracture, Etc.)  
Part of Body: \_\_\_\_\_  
(Back, Finger, Hand, Foot, Etc.)

<b>Human Resources</b>			
Date of 1 <sup>st</sup> Treatment _____	Time _____	<input type="checkbox"/> a.m. <input type="checkbox"/> p.m.	Shift: _____
Sent: <input type="checkbox"/> back to Work <input type="checkbox"/> Doctor <input type="checkbox"/> Home <input type="checkbox"/> Hospital			
Given: First-aid: _____	Estimated Disability: _____ Days		

Location of Occurrence: (State and check all that are applicable):  
Address: \_\_\_\_\_  
 In Shop/Bldg/Compound     Within Entity Boundaries  
 Outside Entity Boundaries     Approved Route/Location

Owner:     County     City     Other (Name/Address) \_\_\_\_\_

Property Identification: \_\_\_\_\_ Year make/age: \_\_\_\_\_ Manufacturer: \_\_\_\_\_

Construction (If not a vehicle, e.g. brick, frame, metal) \_\_\_\_\_

Damage/Loss Description: \_\_\_\_\_

Description/Narrative of Occurrence Discovery (include what employees were doing at the time of occurrence or discovery; why and how): \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Supervisor's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Reviewer's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**City of East Point  
ACCIDENT INVESTIGATION REPORT**

<b>1. Department</b>	<b>2. Work Station:</b>
<b>3. Date of Accident/Incident:</b>	<b>4. Date and Time:</b>
<b>5. Employee Name:</b>	<b>6. Part of Body:</b>
<b>7. Nature of Injury:</b>	<b>8. Object, Equipment, etc. inflicting harm:</b>
<b>9. Occupation:</b>	<b>10. Experience:</b>
<b>11. Drug Testing:</b> <input type="checkbox"/> Yes <input type="checkbox"/> No	<b>12. Claimant Statement Attached:</b> <input type="checkbox"/> Yes <input type="checkbox"/> No
<b>13. Witness Statement Attached:</b> <input type="checkbox"/> Yes <input type="checkbox"/> No	<b>14. Supervisor's Accident Report Attached:</b> <input type="checkbox"/> Yes <input type="checkbox"/> No

**Describe how the event occurred:**

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People	Yes	No	Equipment	Yes	No
Employee job skills and capabilities meet job requirements?	<input type="checkbox"/>	<input type="checkbox"/>	Improper equipment design?	<input type="checkbox"/>	<input type="checkbox"/>
Employee received proper training?	<input type="checkbox"/>	<input type="checkbox"/>	Equipment has required safety controls and guards?	<input type="checkbox"/>	<input type="checkbox"/>
On the job training?	<input type="checkbox"/>	<input type="checkbox"/>	Equipment properly maintained?	<input type="checkbox"/>	<input type="checkbox"/>
New employee training?	<input type="checkbox"/>	<input type="checkbox"/>	Personal protective equipment in good condition?	<input type="checkbox"/>	<input type="checkbox"/>
Standard rules and operating procedures followed and enforced?	<input type="checkbox"/>	<input type="checkbox"/>	Written maintenance program?	<input type="checkbox"/>	<input type="checkbox"/>
Proper personal protective equipment required and worn?	<input type="checkbox"/>	<input type="checkbox"/>	Personal protective equipment available?	<input type="checkbox"/>	<input type="checkbox"/>
Machine guards altered or displaced?	<input type="checkbox"/>	<input type="checkbox"/>	Personal protective equipment fit employee?	<input type="checkbox"/>	<input type="checkbox"/>
Unauthorized employees in restricted areas?	<input type="checkbox"/>	<input type="checkbox"/>			
Material	Yes	No	Environment	Yes	No
Proper storage system used?	<input type="checkbox"/>	<input type="checkbox"/>	Ventilation/lighting system?	<input type="checkbox"/>	<input type="checkbox"/>
Proper handling procedures loading/unloading/transporting?	<input type="checkbox"/>	<input type="checkbox"/>	Workplace layout correct?	<input type="checkbox"/>	<input type="checkbox"/>
Materials used the best on the market/flammability/toxicity?	<input type="checkbox"/>	<input type="checkbox"/>	Employee material handling minimized?	<input type="checkbox"/>	<input type="checkbox"/>
Reactivity and stability?	<input type="checkbox"/>	<input type="checkbox"/>	Housekeeping?	<input type="checkbox"/>	<input type="checkbox"/>
			Nighttime or daytime?	<input type="checkbox"/>	<input type="checkbox"/>
			Weather condition/wind/temperature?	<input type="checkbox"/>	<input type="checkbox"/>
			Surface conditions?	<input type="checkbox"/>	<input type="checkbox"/>

**List Causes:**

**List Recommendations:**

**Accident Investigator's Signature:**

**Witness' Signature:**

**Department Head's Signature:**



**City of East Point  
Foreman's Statement  
Incident/Accident Report**

**DETAILS OF INCIDENT/ACCIDENT**

Report Date: \_\_\_\_\_

Claimant: \_\_\_\_\_

Position: \_\_\_\_\_

Incident/Accident Date: \_\_\_\_\_

Incident/Accident Time: \_\_\_\_ a.m. p.m.

Description of Injuries: \_\_\_\_\_

\_\_\_\_\_

**Yes                  No**

1. Was employee on county property?
2. Was employee performing job assignment?
3. Was employee under control of employer?
4. Was employee on authorized break/lunch period?
5. Was the incident/accident reported immediately?
6. Was employee observed by supervisor prior to incident/accident?
7. Was employee observed by supervisor at time of incident/accident?
8. Were there any witnesses?
9. Were any of the following a factor in the incident/accident?
  - a. Horseplay
  - b. Violation of law/safety rule?
  - c. Failure to follow departmental policy?
  - d. Failure to follow safety policy?
  - e. Deliberate infliction of injury?
  - f. Deviation from work to attend to personal business?
  - g. Intoxication/controlled substance abuse?
  - h. personal problems?
10. Has employee had any prior incidents/accidents?
11. Has employee been employed less than 6 months?
12. Has employee received prompt treatment for any injuries?  
What facility? \_\_\_\_\_
13. Amount of time between incident/accident and time reported?  
\_\_\_\_ Hours \_\_\_\_ Minutes
14. Has incident/accident been reported to Safety Officer?
15. Any disagreement with claimant's statement?
16. Explain what happened: \_\_\_\_\_

\_\_\_\_\_

Signature of Foreman: \_\_\_\_\_ Date: \_\_\_\_\_ Time: \_\_\_\_ a.m. p.m.

**City of East Point  
Witness Statement  
Incident/Accident Report**

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**DETAILS OF INCIDENT/ACCIDENT**

Report Date: \_\_\_\_\_

Witness: \_\_\_\_\_

Claimant: \_\_\_\_\_

Incident/Accident Date: \_\_\_\_\_

Position: \_\_\_\_\_

Position: \_\_\_\_\_

Incident/Accident Time:  a.m.  p.m.

1. In what way were you a witness to the claimant's incident/accident?

**I Observed**

Describe what you saw: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**I Heard**

Describe what you heard: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

2. Where were you located at the time of the incident/accident?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

3. What do you feel was the cause of the incident/accident?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

4. Did you observe any safety violations just prior to this incident/accident?  No  Yes

If "yes", describe what you saw: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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Signature of Witness: \_\_\_\_\_ Date: \_\_\_\_\_ Time:  a.m.  p.m.

Supervisor Receiving: \_\_\_\_\_ Date: \_\_\_\_\_ Time:  a.m.  p.m.

# OFFICIAL NOTICE

This business operates under the Georgia Workers' Compensation Law.

## WORKERS MUST REPORT ALL ACCIDENTS IMMEDIATELY TO THE EMPLOYER BY ADVISING THE EMPLOYER PERSONALLY, AN AGENT, REPRESENTATIVE, BOSS, SUPERVISOR, OR FOREMAN.

If a worker is injured at work, the employer shall pay medical and rehabilitation expenses within the limits of the law. In some cases the employer will also pay a part of the worker's lost wages.

Work injuries and occupational diseases should be reported in writing whenever possible. The worker may lose the right to receive compensation if an accident is not reported within 30 days (see O.C.G.A. § 34-9-60).

The employer will supply free of charge, upon request, a form for reporting accidents and will also furnish, free of charge, information about workers' compensation. The employer will also furnish to the employee, upon request, copies of board forms on file with the employer pertaining to an employee's claim.

A worker injured on the job must select a doctor from the list below. The minimum panel shall consist of at least six physicians, including an orthopedic surgeon with no more than two physicians from industrial clinics (see O.C.G.A. § 34-9-201). Further, this panel shall include one minority physician, whenever feasible (see Rule 201 for definition of minority physician). The Board may grant exceptions to the required size of the panel where it is demonstrated that more than four physicians are not reasonably accessible. One change to another doctor from the list may be made without permission. Further changes require the permission of the employer or the State Board of Workers' Compensation.

### LOCATION: CITY OF EAST POINT - EAST POINT, GA

PRINT NAME:

SIGNATURE:

State Board of Workers' Compensation  
270 Peachtree Street, N.W.  
Atlanta, Georgia 30303-1299  
404-656-3818  
or 1-800-533-0682  
<http://www.sbwrc-georgia.gov>

Now doing business as

**US HealthWorks<sup>®</sup>**  
MEDICAL GROUP

A Dignity Health Member

791 Oak Street  
Hapeville, GA 30354  
(404) 601-2000

Peachtree Orthopedic Clinic  
Dr. Lee Kelley (Backs)  
Dr. Jonathan York (Extremities)  
Dr. James Beskin  
Dr. Xavier Duralde  
1901 Phoenix Blvd. Suite 200  
College Park, GA 30349  
(404) 355-0743

Shear & Freeman MD  
33 SW Upper Riverdale Rd Ste 114  
Riverdale, GA 30274  
(770) 991-1624

**Express Dental**  
Contact: (888) 539 6577

**Express Vision**  
Contact: (888) 539 6577

Dr. Lien Nguyen, Int. Med.  
1029 Cleveland Avenue  
East Point, GA 30344  
(404) 766-4633

Resurgens Orthopaedics  
Dr. Howard McMahan (Backs)  
Dr. Errol Bailey  
Dr. Phani Dantuleri  
550 Peachtree Street 19<sup>th</sup> Floor  
Atlanta, GA 30308  
(404) 215-2000

**NOVA**  
MEDICAL CENTERS

1005 Virginia Avenue  
Suite 100  
Atlanta, Georgia 30354  
404-762-1001

FREE TRANSPORTATION

The insurance company providing coverage for this business under the Workers' Compensation Law is:

**AMTRUST NORTH AMERICA**

Name

P O BOX 740042, ATLANTA, GA 30374-0042

address

678-258-8000

phone

IF YOU HAVE QUESTIONS PLEASE CONTACT THE STATE BOARD OF WORKERS' COMPENSATION AT 404-656-3818 OR 1-800-533-0682 OR VISIT <http://www.sbwrc-georgia.gov>  
Willfully making a false statement for the purpose of obtaining or denying benefits is a crime subject to penalties of up to \$10,000.00 per violation (O.C.G.A. § 34-9-18 and § 34-9-19).

WC-P1 (5/1/12)