

## EMPLOYEE INCIDENT REPORT

Please complete and email to [Quality@ccswv.org](mailto:Quality@ccswv.org)

Incident Type: <input type="checkbox"/> Auto Accident* <input type="checkbox"/> Accident no Injury <input type="checkbox"/> Accident with Injury <input type="checkbox"/> Illness <input type="checkbox"/> Near Miss <input type="checkbox"/> Other <small>*Auto Accidents must complete page 4</small>			
Employee Name:		Employer: <input type="checkbox"/> CCS <input type="checkbox"/> CCSF <input type="checkbox"/> ISN	
Incident Date:	Incident Time:	Time You Began Work:	Incident Location:
Immediately reported to Supervisor: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A If Yes, time? If No, why?		If Accident with Injury Mark all that apply: <input type="checkbox"/> First aid treatment only? <input type="checkbox"/> Doctor Visit <input type="checkbox"/> Hospital Visit <input type="checkbox"/> Hospital Overnight	
Supervisor Name:			
Department or Program:			
Brief Description of Incident (one line summary):			

<b>What was happening <u>before</u> the incident began? (Include as much detail as possible)</b>

<b>Describe the incident? (Include as much detail as possible)</b>
<ul style="list-style-type: none"> <li>What caused or contributed the incident (people, places, things)?</li> <li>What were you doing as the incident occurred?</li> <li>What safety measures or equipment, if any, were in place?</li> <li>What was the immediate response to the incident?</li> </ul>

*We champion the positive development of children and adults, strengthen families and build community.*

**What actions did you take after the incident?**

**If possible, what steps do you plan to take to prevent the incident from recurring?**

Relevance	Name	Signature	Title	Date
Employee Involved				

**Supervisor/Director review & response to incident**

Relevance	Name	Signature	Title	Date
Supervisor/ Director				

*We champion the positive development of children and adults, strengthen families and build community.*

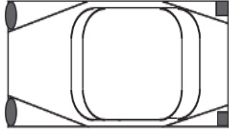





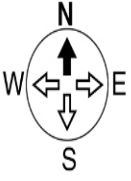
**Safety Coordinator/ Quality Department review & response to incident**

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Relevance	Name	Signature	Title	Date
Safety Coordinator/ Quality Department				

**Motor Vehicle Incident/Accident Details** (check all that apply)  
 (Employee must still file the required Oregon DMV Form 737-32 report as outlined in the CCS Motor Fleet Safety Program.)

<input type="checkbox"/> Company vehicle	<input type="checkbox"/> Customer(s) as passenger(s)	<input type="checkbox"/> Police – cited Employee for
<input type="checkbox"/> Personal vehicle	<input type="checkbox"/> Wearing seat restraints	<input type="checkbox"/> Police – other party cited for
<input type="checkbox"/> Driving	<input type="checkbox"/> Clear weather conditions	<input type="checkbox"/> Vehicle mechanical malfunction
<input type="checkbox"/> Parked	<input type="checkbox"/> Adverse weather conditions	<input type="checkbox"/> Other:

<p><b>Vehicle Damage</b></p> <p>FRONT </p> <p>USE ARROW TO SHOW FIRST IMPACT (SHADE IN DAMAGED AREA)</p> <p><input type="checkbox"/> Vehicle towed  <input type="checkbox"/> Rollover  <input type="checkbox"/> Under car  <input type="checkbox"/> Totaled  <input type="checkbox"/> Unknown</p> <p>You Vehicle (No. 1)</p>	<p><b>Diagram</b></p> <p>Number each vehicle:  </p> <p>Show path by: </p> <p>Show pedestrian/bicyclist by: </p> <p>Show railroad tracks by: </p> <p></p> <p>_____</p> <p>_____</p> <p>--- (name of street, road or route) ↑      --- (name of street, road or route) ↑</p>	<p>↑          (name of street, road or route)</p>
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Vehicle Number/ CCS Fleet Number	
VIN Number (can be find on drivers door jam, through drivers window bottom right, or on the registration in vehicle)	

**Fleet Manager review & response to incident**

Relevance	Name	Signature	Title	Date
Fleet Manager				