CITY OF MESA INCIDENT REPORT

INCIDENT/INJURY/MOTOR VEHICLE COLLISION/PROPERTY DAMAGE

NOTIFICATION (See Safety Plan SS-200 - Accident Reporting)

Incident reports must be submitted **within 24 hours** to Safety Services and City Attorney. **Fatal Incidents must be reported immediately**.

Safety Services
Safety Services (480) 644-3331
- Email "Safety Services"
- Fax (480) 644-5469

City Attorney
- Claims (480) 644-3330
- Email "City.attorney@mesaaz.gov"
- Fax (480) 644-2498

INCIDENT

Date of Incident:	Time of Incident:
Location of Incident:	Date Incident was Reported:
Location Address:	Facility (if applicable):

INCIDENT TYPE (Mark all that apply)
- ☐ Injury
- ☐ Vehicle Collision (2500)
- ☐ Vehicle/Property Damage (2505)
- ☐ Property Damage or Loss (2000)
- ☐ Other: _____

City Vehicle #:	
License Plate #:	
Police Report #:	

VEHICLE COLLISION TYPE (Mark all that apply)
- ☐ Backing
- ☐ Other Vehicle hit City Vehicle
- ☐ City Vehicle hit Other Vehicle
- ☐ Hit Pedestrian
- ☐ Hit Object/Animal
- ☐ Roll Over
- ☐ Side Swipe
- ☐ **Employee operating a City CMV**
- ☐ Other: _____

INCIDENT INVOLVED (Mark all that apply)
- ☐ City of Mesa Employee*****
- ☐ Volunteer
- ☐ Citizen
- ☐ Temporary Agency Worker******
- ☐ Independent Contractor
- ☐ Other: _____

***DOT Post Accident testing** may be required if employee or Temporary Agency Worker was performing DOT covered activities. Contact Jackie Hale at (480) 644-4414 or by cell at (480) 381-0086 to confirm.

****Temporary Agency Workers** may be subject to drug testing by their employer. Contact Human Resources Temporary Coordinator at (480) 644-2189 to confirm.

CITY PERSON INVOLVED

Name:		Employee ID #:	
HRM Department:		**HRM Group Code**:	
Work Phone:		Cell Phone:	
Scheduled Work Days/Shift:		☐ **Stand–In** (Fire Dept.)	☐ **Overtime**
Scheduled Work Hours:	Start time:	End time:	

Incident Description

When providing details of the incident it is important to include information such as: **1)** the activity you were performing at the time of the incident; **2)** any injury you sustained as a result of the incident; **3)** how the incident and injury occurred; and, **4)** any damage to property and/or vehicles.

Injury *Was the City Person involved injured?* ☐ *Yes* ☐ *No*

Was medical treatment given? ☐ Yes ☐ No. If Hospitalized – Hospital Name: _____

Describe medical treatment given: _____

Injured Body Part (mark all that apply)

☐ Head	☐ Foot ☐ R ☐ L	☐ Eye ☐ R ☐ L	☐ Shoulder ☐ R ☐ L
☐ Back	☐ Ankle ☐ R ☐ L	☐ Leg ☐ R ☐ L	☐ Arm ☐ R ☐ L
☐ Other:	☐ Knee ☐ R ☐ L	☐ Wrist ☐ R ☐ L	☐ Hand ☐ R ☐ L

OTHER PERSON INVOLVED

Name:			Date of Birth:
Address:			
Cell:	Home:	Work:	
Email address:			
License Plate #:	Year:	Make:	Model:
If not Driver – Owner's Name:			Owner Phone #:

Incident Description

When providing details of the incident it is important to include information such as: **1)** the activity you were performing at the time of the incident; **2)** any injury you sustained as a result of the incident; **3)** how the incident and injury occurred; and, **4)** any damage to property and/or vehicles.

Injury *Was the Other Person involved injured?* ☐ *Yes* ☐ *No*

Was medical treatment given? ☐ Yes ☐ No. If Hospitalized – Hospital Name: _____

Describe medical treatment given:

WITNESS

Witness Name:		Email Address:
Address:		
Home Phone:	Work Phone:	Cell Phone:

Witness Statement:

SIGNATURES

Form Completed By: _____ Employee ID #: _____

Signature: _____ Date: _____

SUPERVISOR (required)

Was a City employee/volunteer injured? ☐ Yes ☐ No

If so, was the injury to the City employee/volunteer preventable? ☐ Yes ☐ No

Provide details on how preventability was determined or attach the Incident Investigation Report:

If medical treatment was sought:

- Did the City Person go to the City's Directed Care facility, Banner Occupational Health Clinic?
  ☐ Yes ☐ No
- If Yes, please provide the following information:
  - Date/Time the City Person left the workplace or injury site to seek medical attention:
    Date: _____ Time:_____ ◯ am ◯ pm
  - Have you adjusted, or notified your timekeeper to adjust, the employee's timecard to reflect Directed Care as required in the Directed Care Pay Policy? ☐ Yes ☐ No
  - Does the Employee's timecard reflect the Directed Care Pay Code as required? ☐ Yes ☐ No
- Was the Employee mandated to seek medical treatment by his/her supervisor? ☐ Yes ☐ No
  If **Yes**, who mandated treatment? _____

Supervisor Name: _____ Employee ID #: _____

Supervisor Signature:_____ Date: _____

INDUSTRIAL INSURANCE PROGRAM (IIP) ADVANCE PAYMENT AGREEMENT

I, _____, have opted to receive the IIP Advance Payment authorized under Management Policy #346. I have read Management Policy #346 and understand that if my injury is determined compensable by the Workers' Compensation Administration and I am off work for fourteen (14) or more days after the date of injury or subsequent disability because of the injury, I will receive workers' compensation benefits retroactive to the date of injury or disability, resulting in an overpayment of compensation to me. I acknowledge that under these circumstances, I will have been overpaid under the Industrial Insurance Program for all time off work during the first seven (7) days after my injury or subsequent disability because of the injury. Upon written notification, I agree to repay the City for this overpayment of compensation immediately. If I cannot repay the full amount to the City immediately to satisfy the overpayment, I will contact the Payroll Division within seven (7) calendar days to establish a repayment plan. If I fail to contact the Payroll Division within the seven (7) calendar days, I understand that the full amount of the overpayment will be deducted from my pay and the deduction will occur in the next available pay period. I further understand that I am still responsible for any remaining balance after the deduction until the City is repaid in full.

_____ _____

Employee Name (Please Print) Employee #

_____ _____

Employee Signature Date

_____

Date of Injury

Please send original signed copy to the Workers' Compensation Administration