

TRIPLE I REPORT
(Injury-Illness-Accident)

Injured Employees Name: _____ **Dept.:** _____

Home Street Address: _____ **City:** _____ **Zip:** _____

Telephone:() _____ - _____ **SSN:** _____ - _____ - _____

Date of Hire: ____/____/____ **Birth Date:** ____/____/____ **Job Title:** _____

INJURY/ACCIDENT INFORMATION:

Incident Category: **Accident** **Illness** **Vehicular** **Other**

Date of Injury/Accident: ____/____/20____ **Time of Injury/Accident:** ____:____ a.m. p.m.

Accident Classification: **Injury** **Property** **Death**

Injury Type: **First Aid** **Medical Treatment** **Emergency Room**

Chiropractor/Doctor Treating: _____ **Date Injury Reported:** ____/____/20____

Time Shift Began: ____:____ a.m. p.m. **Day of Week:** Su M T W Th F Sa

Report to Supervisor Delayed: **Yes** **No** **If yes, why?** _____

Did injured employee leave work for medical treatment? **Yes** **No**

Comments? _____

Did injured employee return to work after treatment? **Yes** **No**

Comments? _____

Witness(es) to Accident/Injury/Illness? **Yes** **No**

If yes, Names of Witnesses and Phone Numbers: (Witness(es) must complete witness report form immediately)

- | | |
|----------|--|
| 1. _____ | Phone Number: () _____ - _____ |
| 2. _____ | Phone Number: () _____ - _____ |
| 3. _____ | Phone Number: () _____ - _____ |

Was Accident Scene Investigated by Supervisor: **Yes** **No**

If no, why? _____

Injury/Loss

Nature/Extent of Injuries or Property Damage:

WHERE:

Location where Injury/Accident Occurred (Be Specific i.e. , laundry room, Hwy 23 South,):

WHAT:

Description of Accident (Detail of what employee was doing and what physical objects, tools, machines, structures and equipment were involved):

If Co. Vehicle involved, County Vehicle #: _____ Make: _____ Model: _____ Year: _____

Conditions in the area at the time of Accident (Normal, foggy, hot, dusty, raining, etc...)

Employees Signature: _____ Date of Report: ____/____/20__

Supervisors Section

WHY: Specific Root Cause of Accident:

PREVENTION: Suggested changes to prevent reoccurrence of this type of accident?

What action are you taking to see this is being done?

Supervisors Signature: _____ Date of Report: ____/____/20__

OFFICE USE

Lost Time Case: Yes No Number of Days: _____ Actual Estimate

Last Day Worked: ____/____/20__ Returned to Work: ____/____/20__

Light Duty(Restricted): Yes No Number of Days: _____ Actual Estimate

Comments: _____

**Carl Gruber, Safety Risk Manager Ext. 4400, Cell Phone 608-963-2167
Home Phone 608-356-2422**

Routing Slip: _____ _____ _____