Humane Society of Chittenden County
Where Best Friends Meet

EMPLOYEE INCIDENT REPORT

(FOR REPORTING WORK-RELATED INJURIES & ILLNESSES)

Incident reporting ensures there is a record of the incident on file, and helps HSCC provide a safe work environment.

An employee must complete this Incident Report when a work-related injury or illness is sustained.

If the incident being reported involves a bite that breaks skin from an animal, the *Animal Bite Report* needs to be completed as well.

Completed Incident Reports must be submitted to HSCC Shelter Director or President/CEO.

☐ Incident involves a bite from an animal Animal Name_____
☐ Dog ☐ Cat ☐ Other:

EMPLOYEE FULL NAME (PLEASE PRINT):			LAST 4 DIGITS OF SSN:
CELL PHONE:		HOME PHONE:	
HOME STREET ADDRESS:		CITY, STATE, ZIP CODE:	
OCCUPATION/JOB TITLE:			
SUPERVISOR NAME:			SUPERVISOR PHONE:
DATE OF INCIDENT:	TIME OF INCIDENT:	TIME WORK BEGAN:	TIME WORK STOPPED:
FINISHED SHIFT? ___YES ___NO	LOCATION OF INCIDENT (ADDRESS, CITY, STATE, ZIP):		
LOCATION OF INCIDENT (BUILDING NAME, ROOM NAME OR AREA DESCRIPTION):			
DESCRIBE THE INCIDENT (Describe the activity, and any tools, equipment, or materials that you were using):			

CONTINUE ON BACK

LIST THE BODY PART(S) INJURED AND NATURE OF INJURY:	
HOW DO YOU THINK THIS TYPE OF INCIDENT CAN BE PREVENTED IN THE FUTURE?	
TO WHOM DID YOU REPORT THE INCIDENT?	DATE REPORTED:
WITNESS(ES)? ___YES ___NO	IF YES, LIST WITNESS(ES) NAME (S) & PHONE NUMBER(S):
DID YOU RECEIVE TREATMENT? ___Reporting Only (No Treatment Needed) ___I declined treatment at the time ___Treatment was provided ___Treatment will be provided or sought	
IF YOU RECEIVED TREATMENT, WHO PROVIDED IT? ___Self ___Employee Health Services ___Urgent Care ___Emergency Room ___Other (please specify on next line below)	
PROVIDER NAME, ADDRESS & PHONE:	
DESCRIBE THE TREATMENT PROVIDED:	
HAS THE PROVIDER RELEASED YOU FROM CARE? ___YES: Released ___NO: I will return for follow-up	

By signing this form, the employee certifies that the information the employee has provided is true to the best of their knowledge.

_____ _____
EMPLOYEE SIGNATURE DATE SIGNED

_____ _____
SUPERVISOR SIGNATURE DATE SIGNED

In filing this Incident Report you are *not* filing a workers' compensation claim. It is not necessary to fill out a Workers' Compensation Claim Form to obtain first-aid treatment for a minor work-related injury. "First-Aid' means any one-time treatment, and any follow-up visit for the purpose of observation of minor scratches, cuts, burns, splinters, or other minor industrial injury, which do not ordinarily require medical care. This one-time treatment, and any follow-up visit for the purpose of observation, is considered first-aid even though provided by a physician or registered professional personnel.

If your physician indicates that your injury requires medical treatment beyond first-aid or certifies disability beyond your work-shift at the time of injury, you will need to file a Workers' Compensation Claim Form. Please see the Finance & Administration Manager for assistance.