LUCAS COUNTY INCIDENT/ACCIDENT REPORT
(To be completed by the employee and supervisor)

Name: _____ **Assigned Incident #_____**

Department: _____ Job Title: _____

Location of Incident: _____

Incident Date: _____ Time: _____ A.M. P.M.

Date Reported: _____ To Whom: _____

Description of Incident: _____

_____

_____

_____

Witness(es):(Name / Address / Phone) _____

_____

INJURY:

What part(s) of your body was/were affected (be specific: right elbow, left knee, right index finger)

_____

What type of injury did you experience? (be specific: bruise, laceration, pull)

_____

Was first aid provided at the scene? ☐ No ☐ Yes

If yes, please describe: _____

_____

Did you seek other Medical Treatment? ☐ No ☐ Yes

If yes, where? _____

Property / Equipment Damage: (Please include location and description)

_____

_____

_____

Vehicle: Year, Make, Model, VIN# _____

Supervisor's Signature: _____ Date: _____

Medical Release

Under current workers' compensation law, the employer is entitled to a signed medical release.

I hereby authorize any person or persons who have in the past or will in the future medically attend, treat or examine me, or any person who may have information of any kind which may be used to reach a decision in any claim for injury or disease arising from the injury/illness described above, to disclose such information to my employer and/or Managed Care Organization (representative of employer). A copy of this form will serve as the original.

Employee's Signature: _____ Date: _____

☐ Fax Copy to Risk Management at (419) 213-2601