CITY OF HIALEAH

ACCIDENT / INCIDENT REPORT SUPERVISOR COMMENTS

TO BE COMPLETED BY THE SUPERVISOR AND FORWARDED TO RISK MANAGEMENT IN THE OFFICE RISK MANAGEMENT WITHIN 24 HOURS OF THE INCIDENT (FDuharte@Hialeahfl.gov and MS13232@Hialeahfl.gov)

Name of Injured/Claimant: _____ Job Title: _____

Department/Division: _____

Date of Accident: _____ Time of Accident: _____ Type of Incident/Accident:

Accident Location: _____ **Auto** ☐ **W/C** ☐

This Accident Was: Unavoidable ( ) As A Result Of: Unsafe Condition ( )
Avoidable ( ) Unsafe Act ( )

Treatment Rendered: ☐ No Medical Treatment ☐ Medical Treatment

If applicable, where was medical treatment sought? _____

If employee refuses medical treatment, employee must complete and sign Addendum 1 attached to this form.

Recommendation to Avoid Repetition: _____

_____

_____

_____

_____
Supervisors Signature

This is to acknowledge that said employee wishes to file a Worker's Compensation Claim, but by my signature, obligates the City to no liability on the claim, and that determination is made by the carrier. I will conduct trough investigation of the complaint of injury.

Did employee request Form 70-66? Yes:_____ No: _____

If yes, show the date the form was given to the employee: _____
Date

_____
Department Head Signature