

# First Report of Employee or Volunteer Injury/Vehicle or Equipment Damage/Accident

This form is to be completed for all employee or volunteer injuries, vehicle or equipment damage/accident regardless of the extent of injury/damage.

**Submit within 24 hours by email to** **mrincident.dnr@state.mn.us**

**Select “View” then “Edit Document” to fill-in and complete the form**

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| Check all boxes that apply:[ ]  **DNR** **Employee Injury** [ ]  **Volunteer Injury** [ ]  **Vehicle/Equipment Damage or Accident** [ ]  **Near Miss**Checklists, forms, and additional information are available on the DNR [Work Injury Resources](http://intranet.dnr.state.mn.us/safety/workerscomp/index.html) and [Fleet Incident Reporting](http://intranet.dnr.state.mn.us/mr/fleet/accidents.html) intranet pages. |
| Section I. Employee Information |
| Employee ID #: | First Name: | Last Name: | Date of Incident: (mm/dd/yyyy): |
| Time of Incident   [ ]  am [ ]  pm  | Employee Job Title or Classification: | Region: | Division: |
| Date Hired:  | Work Station Location or Park name:  | Work Telephone Number: |
| Work Shift (e.g. M-F 8-4:30)Days Hours  | Does employee receive income from an employer other than the State of MN? [ ]  Yes [ ]  No | Weekly value of 2nd income, if known:  |
| Supervisor Name: | Supervisor Phone Number: | Supervisor Email: |
| Has employee had previous work-related injuries?[ ]  Yes [ ]  No Dates:  | Has employee had previous vehicle/equipment related incidents?[ ]  Yes [ ]  No Dates:  |
| Section II. Employee Injury/ Medical Information (Only complete this section if an injury or illness occurred) |
| Specific part(s) of body affected (e.g. right ankle, back, etc.) | Nature of Injury/Illness (e.g. cut, bruise, sprain, etc.) |
| Time Employee Began Work: [ ]  am [ ]  pm | Date Employer Notified of Incident (mm/dd/yyyy):  | Did the injury cause Lost Time or Restricted Duty beyond the incident date? [ ]  Yes [ ]  No If yes, from what date:  |
| Did employee seek medical care from a provider? [ ]  Yes [ ]  No | Did the incident result in fatality?[ ]  Yes [ ]  No Date of fatality:  | Has the employee returned to work? [ ]  Yes [ ]  NoIf yes, date of return:   |
| Did the incident occur on the employer’s premises? [ ]  Yes [ ] No | Detailed location or site where incident occurred:  |
| Describe in detail how the injury occurred:  |
| What was the injury or illness? (include the parts of the body):  |
| What substances, objects, equipment, tools or machines were involved?  |
| First Date Of Lost Time:[ ]  N/A | Date Employer Notified of Lost Time: [ ]  N/A | Emergency Room Visit:[ ]  Yes [ ]  No | Overnight In-Patient Stay:[ ]  Yes [ ]  No |
| Treating Physician | Hospital or Clinic (name) | Clinic or Physician Phone: |
| Address: | City: | State: | Zip Code: |
| If medical attention was sought, did the employee contact the CorVel Nurseline at 844-235-2055 [ ]  Yes [ ]  No**If yes,** enter the reference number provided by the CorVel here:  |
| InitialTreatment | [ ]  Emergency evaluation. Diag testing and medical procedures[ ]  Hospitalization > 24 hours[ ]  Minor on-site remedies by employer medical staff | [ ]  Future Major Med/Lost Time Anticipated [ ]  Minor clinic/hospital med remedies and diagnostic testing[ ]  No medical treatment |
| **Supervisor should immediately contact CorVel Managed Care at 1-866-436-2542 if an injured employee is admitted to an overnight stay at a hospital or employee requires immediate surgery on the date of injury.** |

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| Section III. Vehicle/Equipment Damage or Accident Information (Only complete this section if a vehicle or equipment was involved) |
| [ ]  Check here if the incident involved outside parties and/or over $1,000 in damage.  |
| Asset Number:  | Make/Model:  | Description (car, truck, tractor, etc.):  |
| Year:  | Mileage:  | Date Notified of Incident (mm/dd/yyyy):  |
| Was a citation issued? [ ]  Yes [ ]  NoIf Yes, for what?  | Does employee have a valid driver’s license? [ ]  Yes [ ]  NoLicense Class [ ]  A [ ]  B [ ]  C [ ]  D Driver’s License Number:  |
| Operator Training Information:* Date of last Defensive Driver’s Training:
* Date of Towing & Trailer Safety Training (if the incident involved a trailer):
* Date of qualification (if the incident involves off-road equipment):
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| Damage to vehicle or equipment – please describe in detail:  |
| Initial damage estimate to DNR vehicle or equipment: $ |  |
| Year and make of other vehicles or equipment Involved:  | Initial damage estimate to other damaged vehicles or equipment:$ |
| Section IV. Supervisor’s Analysis of Accident (Mandatory) |
| Detail what the employee was doing prior to the incident and how the incident occurred.  |
| From your investigation, what was the cause(s) and contributing factors of the incident?  |
| What steps have or will be taken to prevent this type of incident in the future?  |
| Were there witnesses to the incident/injury?  [ ]  Yes [ ]  No | Witness Name(s):  | Witness Phone Number(s):   |
| Employee signature: | Employee’s Supervisor signature: | 68. Regional Manager signature: |

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| Supervisor’s Instructions for Submitting |
| 1. Scan and email to: mrincident.dnr@state.mn.us within 24 hours, even if it is preliminary. Signed final reports can be submitted later.
2. Forward a copy to your manager and/or others as required by your division.
3. Retain a copy for your records.
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| For assistance or questions about completing this form |
| **Employee or volunteer injuries**- visit the [Work Injury Resources](http://intranet.dnr.state.mn.us/safety/workerscomp/index.html) webpage or contact the Workers’ Compensation Coordinator**Vehicle or equipment damage or accidents**- visit the [Incident Reporting Procedure](http://intranet.dnr.state.mn.us/mr/fleet/accidents.html) webpage or contact your [Regional Fleet Staff](http://intranet.dnr.state.mn.us/mr/fleet/contacts.html) **Near misses**- contact your [Regional Safety Administrator](http://intranet.dnr.state.mn.us/safety/workerscomp/contacts.html). |

Insert notes or pictures below (optional)

