EXHIBIT B

City of Duluth Incident/Injury Report

Supervisor to complete within 24 hours of incident/injury. If injury required treatment by a medical provider, attach medical documentation. Completed forms should be emailed to accidentreporting@duluthmn.gov.

Date of incident/injury:	☐ Employee ☐ Non-Employee	Department/Division:
Choose one that best describes this claim: ☐ Incident only, no medical care ☐ Medical only, no lost time ☐ Injury includes lost time		
Initial treatment sought: ☐ Hospital ER ☐ Clinic ☐ Refused to see MD / None		Doctor/clinic name, address, phone number:

Last name:	First name:		MI:	SSN:
Address:				
City:	State:	Zip code:	Phone:	Date of birth:
Date of hire:	Occupation:			Gender: ☐ Male ☐ Female

Did injury occur on employer's premises? ☐ Yes ☐ No	Name and address of the place of the occurrence:
Time employee began work: _____ ☐ a.m. ☐ p.m. Time of injury: _____ ☐ a.m. ☐ p.m. Date employer notified of injury: _____ Date employer notified of lost time: _____ First date of any lost time: _____ Return to work date: _____ RTW with restrictions: ☐ Yes ☐ No ☐ N/A	
Describe the nature of the illness or injury. Be specific. Include body parts affected.	
Describe the activities when injury occurred with details of how it happened.	
What tools, equipment, machines, objects and/or substances were involved?	

Incident investigation conducted: ☐ Yes ☐ No Date supervisor notified: _____ Date report completed: _____ Supervisor name: _____ Supervisor phone number: _____
Names and phone numbers of witnesses:
Incident was a result of: ☐ safety violation ☐ machine malfunction ☐ product defect ☐ motor vehicle accident ☐ N/A
Supervisor comments:
What actions have been taken to prevent recurrence?

City of Duluth Incident/Injury Report

CAUSE

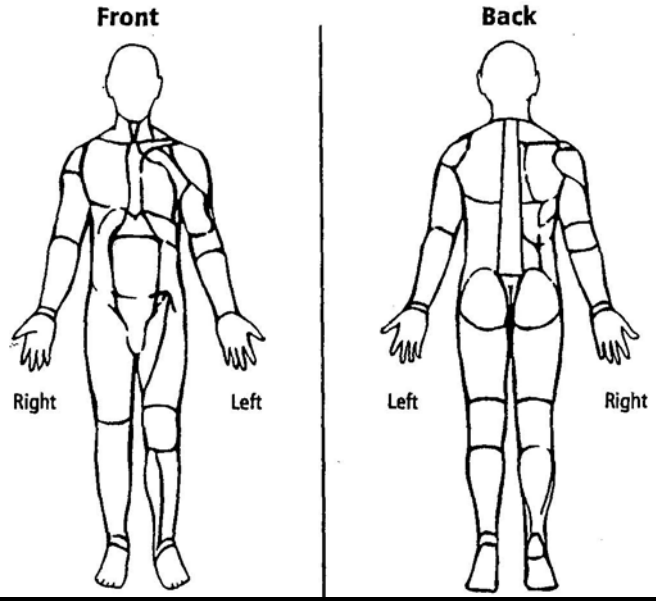
☐ Slip and fall
☐ Struck by equipment
☐ Lifting or moving
☐ Caught (in, on, or between)
☐ Needle puncture
☐ Object in eye (☐ Right ☐ Left)
☐ Repetitive/overuse
☐ Other (specify): _____

TYPE OF INJURY

☐ Scrape/bruise
☐ Sprain/strain
☐ Puncture wound
☐ Cut/laceration
☐ Concussion
☐ Bite
☐ Chemical burn/rash/breathing difficulties
☐ No apparent injury
☐ Other (specify): _____

MARK AREAS OF INJURY BELOW:

Areas can be marked by typing an "X" in the text box wherever needed.



COMPLETE FOR VEHICLE, EQUIPMENT, OR PROPERTY DAMAGE

For vehicle accidents: Attach sketch and additional information of how vehicle accident occurred.
Include street names, direction of travel, locations of vehicles, objects and traffic control devices (↑ North)

Incident Location:		Time of incident: _____ ☐ a.m. ☐ p.m.	
Police called: ☐ Yes ☐ No		Police Traffic Accident Report ICR #:	
City vehicle, property, or equipment involved	Description:		
	Vehicle #:	Make/Model:	Year:
	Describe damage:		
Non-city vehicle, property, or equipment involved	Owner full name:		☐ Driver ☐ Passenger ☐ Other
	Owner address:		
	Owner phone number:	Vehicle license #:	
	Make/Model:	Color:	Year:
	Describe damage:		

Weather conditions:
☐ Clear ☐ Wind
☐ Rain ☐ Cloudy
☐ Fog ☐ Sleet
☐ Snow

Roadway conditions:
☐ Dry ☐ Mud
☐ Wet ☐ Paved
☐ Snow ☐ Unpaved
☐ Ice

Light conditions:
☐ Night
☐ Day
☐ Good
☐ Poor

Approximate temperature: _____ °F
Estimated speed: _____ mph
Vehicle: ☐ Loaded ☐ Empty
What was load: _____
Drug and/or alcohol test? ☐ Yes ☐ No ☐ N/A

The Incident/Injury Form should be printed and signed by supervisor and employee. Completed forms can be scanned to accidentreporting@duluthmn.gov.

Supervisor Signature: _____ Date: _____

Employee Signature: _____ Date: _____