



San Juan County – Office of the County Manager

350 Court St. #5 (mail) / 55 Second Street (office) / Friday Harbor, WA 98250
(360) 378-3870 / FAX (360) 370-5085

SAN JUAN COUNTY INCIDENT REPORT

Use this form to report an accident, incident, or injury.

Internal Guidance Document - Last updated April 2013

PURPOSE

The purpose of an Incident Report is to alert the County Risk Manager and other County departments to risks or hazards that need to be resolved. Filing an Incident Report helps protect you as a County employee, and allows timely and fair resolution of incidents or accidents that could lead to claims or lawsuits.

The sooner the Risk Manager knows of the problem, the sooner he or she can assess the risk and, in some cases, actively engage the claimant to solve the problem. Time is therefore of the essence—please alert the Office of the County Manager at 370-7402 (Kandy Seldin) or 370-7403 (Pamela Morais) and file an incident report as soon as possible, after learning of an incident or accident.

WHEN AND HOW TO FILE AN INCIDENT REPORT

An Incident Report must be filled out by County personnel only, including employees and volunteers. The Report should not be given to or discussed with an injured person or a third party who is not a County employee.

File an Incident Report for accidents or incidents in which the County may have some liability, for either property damage or personal injury. File a report for all incidents that involve injuries and/or property damage to:

- County personnel or volunteers;
- Members of the public; or
- Property damage caused by or attributable to a County employee or severe property damage to County property.

HOW TO REPORT “HAZARDS”

Hazards include unstable or dangerous buildings or infrastructure, nuisances on County property, road hazards, damaged road signs, unsafe road conditions, etc. Unsafe conditions in any county building or on county property should be reported immediately to the Public Works department at 370-0500. Other safety matters should be reported to the Office of the County Manager at 370-7402.

WHAT TO DO AFTER A TRAFFIC COLLISION

First aid is always the first thing to do after a traffic collision. All traffic collisions should be reported immediately to the appropriate law enforcement agency. All County personnel involved in a traffic collision while on County business or in a County vehicle must not make any statements at the scene except to a law enforcement officer. No statements should be made to any party or witnesses to the accident. "Fault" should not be acknowledged, because "fault" is a legal determination that will be made at a later date and is often different than what one feels emotionally at the scene. Fault is very difficult to ascertain at the scene of an accident where there is confusion, and critical facts can be unknown.

County personnel involved in an accident must record on the Incident Report the names, addresses and telephone numbers of all participants in the accident and all known witnesses. A traffic accident booklet (kept in the glove box of County vehicles) can be used for auto accidents in lieu of this Incident Report.

TIME TO COMPLETE AN INCIDENT REPORT

All accidents involving County personnel shall be reported by telephone as soon as possible to the appropriate department head/supervisor and the Office of the County Manager at 370-7402, or the Sheriff's business line after hours at 378-4151.

Within 24 hours:

1. An employee or volunteer involved in an accident shall prepare a written Incident Report (the supervisor should complete it if the employee cannot).
2. The Incident Report must be signed by the employee's department head or supervisor.
3. The report should be delivered immediately (or faxed to 370-5085) to the Office of County Manager.

When medical attention is required for a job-related injury, a separate worker's compensation claim form must also be filled out by the employee and the medical provider. The medical provider will provide the injured employee with the necessary form. Worker's compensation claim files will be maintained by the Office of the County Manager.

Incident Reports may be forwarded to the Prosecuting Attorney to assist the Prosecuting Attorney with case investigation. To the extent permitted by law, Incident Reports will be kept confidential.



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INCIDENT REPORT FORM

NAME OF EMPLOYEE/VOLUNTEER COMPLETING FORM:	POSITION / DEPARTMENT:
DATE AND TIME OF INCIDENT:	LOCATION OF INCIDENT:
LIST ANY WITNESSES AND IF AVAILABLE, THEIR PHONE NUMBER(S):	

This is a report of (check all that apply):

- | | | | |
|--------------------------|--|--------------------------|---|
| <input type="checkbox"/> | Damage to equipment, material or property. (complete section #1) | <input type="checkbox"/> | First aid injury. (complete section #3) |
| <input type="checkbox"/> | Vehicle accident. (complete sections #1 and #2) | <input type="checkbox"/> | Injury requiring medical attention. (complete section #3) |
| | | <input type="checkbox"/> | Fatality (complete section #3) |

SECTION #1 - For reporting vehicle accidents and/or damage to equipment, material or property.

Describe the event and what property was damaged (vehicle, equipment, building, etc.):

SECTION #2 - For reporting vehicle accidents.

Was County vehicle involved? <input type="checkbox"/> Yes <input type="checkbox"/> No	Was County employee or volunteer's personal vehicle involved? <input type="checkbox"/> Yes <input type="checkbox"/> No	Was a private citizen's personal vehicle involved? <input type="checkbox"/> Yes <input type="checkbox"/> No
If yes,	If yes,	If yes,
Vehicle make and model:	Vehicle make and model:	Vehicle make and model:
Vehicle license #:	Vehicle license #:	Vehicle license #:
Operator's driver's license #:	Operator's driver's license #:	Operator's driver's license #:
	Personal auto insurance company:	Personal auto insurance company:
	Personal auto insurance policy #:	Personal auto insurance policy #:

SECTION #3 – Injuries or fatalities.

Name of person injured:

Mailing address of injured person:

Phone number(s) for injured person:

Was medical treatment required? Yes No

If yes, what type of treatment? First Aid Doctor/Hospital Other _____

Briefly describe the circumstances of the injury:

EMPLOYEE / VOLUNTEER'S SIGNATURE:

DATE:

SUPERVISOR'S REPORT OF ACCIDENT

Date and time accident/injury was reported to you:

For injuries, number of hours and workdays lost:

Task being performed when accident/injury occurred:

What actions, events, or conditions contributed to this accident/injury?

Could anything be done to prevent this type of injury? Yes No
If yes, please explain:

SUPERVISOR'S SIGNATURE:

DATE:

SUPERVISOR'S TITLE:

DEPARTMENT: