



# CITY OF GARDNER

## ACCIDENT/INCIDENT REPORTING AND TREATMENT FORM Public Safety Personnel

Name of Employee: \_\_\_\_\_ Social Security # \_\_\_\_-\_\_\_\_-\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_

Address: \_\_\_\_\_ City \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: (\_\_\_\_) \_\_\_\_\_ Work Phone: (\_\_\_\_) \_\_\_\_\_

Department:     Police             Fire            Position Title: \_\_\_\_\_

Date of Injury \_\_\_\_/\_\_\_\_/\_\_\_\_            Time \_\_\_\_\_ AM/PM            Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_

Name of Supervisor: \_\_\_\_\_ Title: \_\_\_\_\_

Wage Per Hour: \_\_\_\_\_            Average Weekly Earnings: \_\_\_\_\_

No. of Hours Worked Per Day: \_\_\_\_\_            No. of Days Worked per Week: \_\_\_\_\_

Scene of Accident/Incident: \_\_\_\_\_

Witness(es): \_\_\_\_\_

Describe What Happened, include substances, materials or vehicles involved, including nature of injury and body part affected: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

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I hereby authorize The City of Gardner (or any of its representatives), to be furnished any information and facts regarding this injury, including reports and records, results of diagnosis, treatment and prognosis, estimates of disability, and recommendations for further treatment. This information is to be used for the purpose of evaluating and handling my claim for injury as a result of the above incident and for no other purpose. A photocopy of this release shall serve and be as valid as the original. This release shall be valid until withdrawn by me in writing.

Signature of Employee \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_

Signature of Supervisor \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_

**Please complete Page 1 of form and return it to the Personnel Department. Should you require medical treatment, Page 2 of the form should be completed by your medical provider and returned with Page 1.**

