CITY OF HAVERHILL - ACCIDENT REPORT: _____ _____

EMPLOYEE NAME DEPARTMENT

EMPLOYEE INFORMATION	
Address:	
City, State, ZIP:	
Telephone #:	
Social Security #:	
Date of Birth:	
Employee signature:	
Date reported to department:	

INJURY INFORMATION			
Date of Injury:		Date of Submission:	
Witness(es):			
Place where injury occurred:			
Describe how injury occurred:			
Injured Body Part(s): (ie; left hand; right hand;etc)			

PHYSICIAN SECTION			
Doctor seen:		Hospital/center:	
Diagnosis/Prognosis:			
Nature & extent of injury: (describe treatment)			
Is further medical attention necessary?		Yes ☐	No ☐
Is patient able to perform usual duties?		Yes ☐	No ☐
Is patient able to perform light duties?		Yes ☐	No ☐
If unable to work, specify when patient can return:			
Physician Signature:			

Reviewed & approved by: Reviewed by:

_____ _____ _____

Chief Robert O'Brien – Fire Department Human Resources Director Date

Original to RETIREMENT **cc: Department & Employee**