CITY of BILLINGS ACCIDENT/INJURY FORM

(Revised October 2025)

REPORT OF:
(Check all that apply)

- ☐ Employee on-the-job injury*
- ☐ Occupational illness*
- ☐ Damage to City property
- ☐ Damage to citizen's property or person

THIS FORM MUST BE COMPLETED AND SUBMITTED TO THE SAFETY OFFICER. EMAIL TO vergerj@billingsmt.gov or FAX TO 657-8390, or SEND VIA COURIER. A DRAFT COPY IS REQUIRED WITHIN 3 WORKING DAYS, EVEN IF/WHILE YOU ARE ATTEMPTING TO ROUTE FOR REVIEW AND SIGNATURES.

EMPLOYEE

Employee: _____ Dept & Position: _____ Work Phone: _____

Supervisor: _____ Supervisor Phone: _____

INCIDENT

Date & Time of Incident: _____ Address/Location of Incident: _____

Describe what occurred: _____

Investigating Police Officer: _____ Report No.: _____

CDL Holders: Was employee drug & alcohol tested? _____ If no, why not _____

(Employee must be immediately tested if any one of the following occurs: (1) a fatality; (2) medical treatment is required away from scene and City driver cited; or (3) if either vehicle is disabled and City driver receives a citation. If testing is not conducted, we must specify why it was not necessary).

EMPLOYEE INJURY

Type of Injury and Part(s) of Body * _____

(*Be specific. e.g., sprained R ankle, bruised L wrist, etc.)

Did or will the employee seek medical treatment? _____ Name of Dr./Hospital: _____

Type of medical treatment: _____

(Must submit doctor's statement/restrictions/release)

Did a doctor remove the employee from work? _____ Date(s) of absence: _____

Did a doctor impose restrictions or limitations due to this injury? _____

If yes, explain: _____

*{This is my claims for workers' compensation benefits due to an on-the-job injury, occupational disease or death of the above named worker. I **understand** that signing this claim for compensation authorizes the release of rehabilitation records, Social Security records and health care information (medical records) **relevant to** this claim to the workers' compensation insurer and insurer's agents. **I also understand** that if I obtain or exert unauthorized control over workers' compensation benefits, I may be fined and/or imprisoned. City policy states that an absence required as the result of a work injury runs concurrently with leave provided under FMLA.}*

CITY VEHICLE AND/OR OTHER CITY PROPERTY

Description of Property _____

Vehicle Year, Make & Model _____ Vehicle No.: _____

Description of Damage (Attach/Enclose photos): _____

_____

CITIZEN/OTHER PARTY INFORMATION

Name: _____ Address: _____ Phone(s): _____

City/ST/Zip _____ Phone(s): _____

Driver Name (if different than above): _____ Phone(s): _____

Owner Name (if different than above): _____ Phone(s): _____

Description of Damage (Attach/Enclose photos): _____

Vehicle Year/Make/Model: _____ License Plate No.: _____ VIN: _____

Insurance Company: _____ Policy No: _____

Agent: _____ Agent Phone: _____

Citizen injuries and treatment: _____

Doctor or Hospital: _____

WITNESSES: (Attach signed witness statements as appropriate)

Witness Name: _____ Phone: _____ Address: _____

Witness Name: _____ Phone: _____ Address: _____

Witness Name: _____ Phone: _____ Address: _____

SUPERVISOR'S SECTION

Date/time employee reported incident to you: _____

Based on your investigation, what was the cause of this accident? **(Select all that apply)**

UNSAFE ACT

- ☐ FAILURE TO FOLLOW RULES
- ☐ IMPROPER PROCEDURE
- ☐ HASTE
- ☐ FAILURE TO OBTAIN HELP
- ☐ IMPROPER USE OF TOOLS/ EQUIPMENT
- ☐ INATTENTION OR DISTRACTION
- ☐ FAILURE TO USE PPE

UNSAFE CONDITION

- ☐ UNSAFE LAYOUT
- ☐ UNSAFE EQUIPMENT/FACILITIES
- ☐ INSUFFICIENT EMPLOYEE TRAINING
- ☐ ACTION OF ANOTHER PERSON
- ☐ PERSONAL PHYSICAL CONDITION
- ☐ OTHER (EXPLAIN) _____

Supervisor's comments – Including what specific corrective actions have been/will be implemented to prevent similar injuries? _____

_____

_____

SIGNATURES:

Employee: _____ Date: _____

Supervisor: _____ Date: _____

Dept/Division Head: _____ Date: _____

FAX completed form to 657-8390 or email to Jolynn Yerger at yergerj@billingsmt.gov.

NOTE: IN THE EVENT A WORKPLACE ACCIDENT RESULTS IN AN EMPLOYEE ***DEATH***, THE RISK & SAFETY OFFICE MUST PROVIDE NOTICE TO THE MT SAFETY & HEALTH BUREAU **WITHIN 8 HOURS** TO 1-844-669-5461 OR TO: https://erd.dli.mt.gov/safety-health/workplace-fatality-reporting.

IN THE EVENT A WORKPLACE INJURY RESULTS IN ***IN-PATIENT HOSPITALIZATION, AMPUTATION OR LOSS OF AN EYE,*** THE RISK & SAFETY OFFICE MUST PROVIDE NOTICE TO THE MT SAFETY & HEALTH BUREAU **WITHIN 24 HOURS** TO 1-844-669-5461 OR TO: https://erd.dli.mt.gov/safety-health/workplace-fatality-reporting.