TRAVIS COUNTY EMERGENCY SERVICES DISTRICT #1

EMPLOYEE INJURY FORM

Name: _____

Position: _____

Date: ____ / ____ / _____

Exact Time of incident: _____ Date: ____ / ____ / _____

Location where accident occurred:

_____

_____

_____

Name of person to whom this accident was reported:

_____ Rank: _____

Time reported: _____ Date: ____ / ____ / _____

Name(s) of witnesses:

_____ Rank: _____

_____ Rank: _____

Summarize what happened:

_____

_____

Explain in detail: What part of the body was injured, be specific:

_____

Firefighter's Signature: _____ Date: ____ / ____ / _____

Officer's Signature: _____ Date: ____ / ____ / _____

This form is to be turned in to your Officer within 48 hours of the Incident.

NOTICE: