DEKALB COUNTY LIABILITY INCIDENT REPORT
(THIS FORM **NOT** TO BE USED FOR WORKERS COMPENSATION CLAIMS)

Date of Incident:_____ Time of Incident:_____

Date of Report: _____

Department or Building: _____

Name of County Employee Involved: _____

Name of Non-Employee Involved: _____

Address: _____

_____

Any Injury Resulting: _____

_____

Location of Incident: _____

Description of Incident: _____

_____

_____

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Report Preparer: _____ Date: _____