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: _____

_____

_____

_____

_____

_____

Report Preparer: _____ Date: _____