How to Report an Injury

FOR SUBSTANTIAL INJURY OR DEATH - CALL STEPHANIE 850-261-0089

If you are injured on the job, follow these instructions:

If your injury is a life threatening emergency dial 911

If your injury is NOT life threatening, Immediately report it to your employer. That means your direct supervisor or department director. Supervisor should notify HR to obtain authorization for treatment.

Where to I go for medical treatment?
For injuries sustained during normal business hours, seek care at:

Concentra
6235 N. Davis Hyw, Suite 113
Pensacola, FL 32504
Phone - 850-203-9121
Locations Hours: M – F 8 a.m. - 5 p.m.

For after-hours AND emergency care, our approved 24-hour-a-day provider is: **Gulf Breeze Hospital**
1110 Gulf Breeze Pkwy
Phone: 850-934-2020

INFORM THE MEDICAL FACILITY THAT YOUR INJURY IS WORK-RELATED
INSURANCE CARRIER: Public Risk Management, Davies, Inc. P O Box 110279, Lakewood Ranch, FL 34211

PUBLIC RISK MANAGEMENT
Call: 1-800-749-3044
24 hours a day, 365 days a year

- to report the injury
- to receive first aid information
- to receive authorization for treatment

Post Accident Alcohol Testing
ProHealth Medical Care
3298 Summit Blvd, Ste 33
Pensacola 850-434-4991
After-hours collections call:
Debbie DuFour 712-7486
Dewayne Wright 619-1854

Provide Employee with ScriptAdvisor Temporary Prescription Benefit Card.

An injured worker has an obligation to report a work related accident within 30 days after he or she knew, or should have known, an injury in the course and scope of employment was sustained.

City of Gulf Breeze

CITY INCIDENT REPORT

INSTRUCTIONS: THIS FORM IS FOR CITY INCIDENTS ONLY. PLEASE TURN IN TO YOUR DIRECT SUPERVISOR/DEPARTMENT DIRECTOR.

☐ First Aid Only

INCIDENT INFORMATION:

DATE:	TIME:	LOCATION:

INDIVIDUAL INJURED:

NAME:			CITY EMPLOYEE: ☐ YES ☐ NO
ADDRESS:	CITY:	STATE:	ZIP:
HOME PHONE NO.:	MOBILE PHONE:		DATE OF HIRE:
SS#:	DOB:	GENDER:	EMAIL: DEPT

INJURY:			
DATE FIRST REPORTED:		JOB TITLE	DEPT:
SUPERVISOR:	WORK PHONE NO.:	OFFICE LOCATION:	

DETAILED DESCRIPTION OF INCIDENT (USE ANOTHER SHEET IF NECESSARY):

INJURY INFORMATION:

IF INJURED, DESCRIBE & INDICATE PART OF BODY AFFECTED:	
DID INDIVIDUAL REQUEST MEDICAL AID: YES NO	IF YES, PROVIDER:
PROVIDER'S ADDRESS:	PHONE NO.:

CONDITIONS:

FLOOR:	WEATHER:
OTHER SIGNIFICANT CONDITIONS:	

WITNESS NAMES:	CITY EMPLOYEES RESPONDING:

EMPLOYEE COMPLETING FORM:	DATE: