CONFIDENTIAL

City of Flagstaff

Traumatic Event Reporting Form

Officer Craig Tiger Act

In compliance with A.R.S. § 38-672 & 38-673

Employee Information

Full Name: _____ Date: _____
Last *First* *M.I.*

Title: _____

Personal Email: _____

Phone: _____ Cell: _____

Supervisor: _____ Select one: POLICE DEPARTMENT ☐ FIRE DEPARTMENT ☐

Traumatic Event Information

Date of Event: _____ Location/ Address: _____

Date Reported: _____ Reported to: _____

Police Report #: _____

Are you going to file a Worker's Compensation Claim? If yes, you will need to file the claim separately. YES ☐ NO ☐

Do you believe this incident/injury is work related?? YES, but I do not wish to file a Worker's Compensation Claim at this time. ☐ NO ☐

Provider Options

1. City's provider – Dr. Dallacqua 928-774-6364
2. Seek treatment through your own provider.
   -A Provider Packet must be completed by the provider.

Disclaimer and Signature

I certify that my answers are true and complete to the best of my knowledge.

Signature: _____ Date: _____

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After Treatment Follow-up

This section to be completed after treatment for state required reporting purposes. HIPAA information will not be provided with report.

How many months did you participate? From:_____ To:_____

How many visits did you utilize? _____

How many days of work were missed? _____

If you were out on an extended leave, when did you return to duty? _____