CONFIDENTIAL Traumatic Event Reporting Form CONFIDENTIAL

Officer Craig Tiger Act A.R.S. §38-672

PAR 3-15

For Use by Sworn Fire and Police Personnel Only

Employee Information

Employee Name:	Department: _____	Employee ID #: _____
Date of Event: _____	Shift/Schedule: _____	
Job Title: _____	Supervisor Name: _____	

Traumatic Event Type

Is this related to a traumatic event as defined by A.R.S. §38-672 (Officer Craig Tiger Act) based on meeting one or more of the criteria below? Please check all that apply.

☐ Yes ☐ No

☐ Visually witnessing the death or maiming or visually witnessing the immediate aftermath of the death or maiming of one or more people.

☐ Responding to or being directly involved in an criminal investigation of an offense involving a dangerous crime against children as defined in A.R.S. 13-705

☐ Requiring rescue in the line of duty where the individual's life was in danger

☐ Using deadly force or being the subject of deadly force, regardless of injury;

☐ Responding to or being directly involved in an investigation involving the drowning or near drowning of a child

☐ Witnessing the death of another First Responder

Traumatic Event Information

Physical Address: _____

Physical Location: _____

Brief Description of the Event: _____

Employee Acknowledgement

☐ Check here if you wish to file this injury/incident as a Workers Compensation claim (if you check this box, please complete the "Employee's Injury/Incident Report" in addition to this form).

☐ I believe this incident/injury is work related, but at this time I do not wish to file a Workers' Compensation claim.

☐ I believe this incident/injury is not work related and is personal medical.

I certify that all statements in this report are true, and I agree and understand that any misstatement or omission of material fact herein may constitute cause for disciplinary action up to and including termination. Please reference PARs 3-15, 9-2

Employee Signature: _____

Department Incident Number: _____

FOR HR USE ONLY:

Traumatic Event ID Number: _ _ _ _ _ _ - _ _ _ _ _ _ _ _ _ _ Workers Comp Claim Number: _____ (if applicable)