WORKPLACE INCIDENT REPORT FORM

Date of Report: _____, 20____

PERSON INVOLVED

Name: _____

Address: _____

Phone: _____ E-Mail: _____

THE INCIDENT

Date of Incident: _____, 20____ Time: ____:_____ ☐ AM ☐ PM

Location: _____

Describe the Incident: _____

_____

_____

_____

Did the employee leave work? ☐ Yes ☐ No

If yes, what time? ____:_____ ☐ AM ☐ PM

When did employee return to work? _____, 20____

INJURIES

Was anyone injured? ☐ Yes ☐ No

If yes, describe the injuries: _____

_____

_____

WITNESSES

Were there witnesses to the incident? ☐ Yes ☐ No

If yes, enter the witnesses' names and contact info: _____

_____

_____

POLICE / MEDICAL SERVICES

Police Notified? ☐ Yes ☐ No If yes, was a report filed? ☐ Yes ☐ No

Was medical treatment provided? ☐ Yes ☐ No ☐ Refused

If yes, where was medical treatment provided? ☐ On site ☐ Hospital ☐ Other: _____

If medical treatment was provided off-site, provide facility name and address:

_____

_____

PERSON FILING REPORT

Print Name: _____

Signature: _____ Date: _____, 20____

Supervisor Signature: _____