Incident Report

Part One - To Be Completed by Employee

The Arc
Prince George's County

Agency Name: _____ Employee ID# _____

1. Employee Name: _____

2. Address: _____ City: _____

3. County: _____ State: _____ Zip: _____

4. Home Phone : _____ Cell Phone: _____

5. Social Security: _____ DOB: _____ Gender: _____

6. Date of Hire: _____ Job Title: _____ F/P Time: _____

7.Days/Hours Work per Week: _____

8. Date of Accident or Injury: _____ Time: am/pm _____

9. Location of Incident (address): _____

10. Describe the injury or illness: Specific activity the employee was engaged in when the incident occurred ? (use a second page if necessary):

_____

_____

_____

11: Witnesses: Name and Phone Number _____

12. What were witnesses doing at time of incident? _____

13. When did you first report this incident? Date: _____ Time: _____

14. Did you finish work the day of the incident? Yes _____ No _____

15. What part(s) of the body was /were affected (be specific)? _____

16. Will you be seeking medical consultation or treatment for this injury? Yes _____ No _____

17. Describe any medical treatment you received or will receive: _____

18. Please provide the medical provider:
Name: _____ Phone number: _____
Address: _____

I certify that this information is true and correct to the best of my knowledge and belief.

Employee Signature: _____ Date: _____

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Incident Report

Part Two - To Be Completed by Employer / Supervisor

19. Employee Name: _____ Incident Date: _____

20. When did you first learn about the injury / illness or accident?
Date: _____ Time: am/pm _____ Who reported it to you? _____

When did you first speak with the employee about the incident?
Date: _____ Time: am/pm _____

Describe in detail what the employee reported to you (be as specific as possible):

_____

_____

_____

What areas of the body were affected by the injury / illness or accident?

_____

_____

_____

21. Did you speak with any witnesses? Yes _____ No _____

22. Identify potential witnesses:
Name: _____ Phone number: _____

What was their location at the time of the incident? _____

Identify potential witnesses:
Name: _____ Phone number: _____

What was their location at the time of the claim occurrence? _____

23. Did the employee complete his/her shift or day? Yes _____ No _____

24. Did the employee request/receive any medical treatment? (Explain) Yes _____ No _____

_____

Name of Medical Provider: _____
Address: _____
Phone Number: _____

I certify that this information is true and correct to the best of my knowledge and belief.

Date: _____ Supervisor's Signature: _____
Print Name: _____

Date: _____ Dept Director's Signature: _____
Print Name: _____