

# Incident Report

## Part One - To Be Completed by Employee



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: \_\_\_\_\_



# 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: \_\_\_\_\_