**WORKPLACE INCIDENT REPORT FORM**

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| **EMPLOYEE FILING REPORT** |

**Employee Name**: [FULL NAME] **Job Title**: [JOB TITLE]

**Supervisor Name**: [SUPERVISOR NAME]

**Signature**: [\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_](https://esign.com/) **Date**: [DATE]

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| **INCIDENT DETAILS** |

**Date of Incident**: [DATE OF INCIDENT] **Time**: [TIME] [ ]  AM [ ]  PM

**Location**: [LOCATION]

**Incident Type**: [ ]  Injury [ ]  Illness [ ]  Near Miss [ ]  Observation [ ]  Other: [OTHER]

**Describe the Incident**: [DESCRIBE THE INCIDENT]

**Describe what could have been done to prevent the incident**: [DESCRIBE PREVENTATIVE MEASURES]

**Has the employee’s supervisor been notified about the incident?** [ ]  Yes [ ]  No

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| **PARTIES INVOLVED** |

1. **Full Name**: [FULL NAME] **Phone**: [PHONE] **E-Mail**: [EMAIL]

**Address**: [ADDRESS]

1. **Full Name**: [FULL NAME] **Phone**: [PHONE] **E-Mail**: [EMAIL]

**Address**: [ADDRESS]

1. **Full Name**: [FULL NAME] **Phone**: [PHONE] **E-Mail**: [EMAIL]

**Address**: [ADDRESS]

1. **Full Name**: [FULL NAME] **Phone**: [PHONE] **E-Mail**: [EMAIL]

**Address**: [ADDRESS]

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| **INJURIES** |

**Was anyone injured?** [ ]  Yes [ ]  No

**If yes, describe the injuries**: [INJURY DESCRIPTION]

**If the employee was injured, did they see a doctor?** [ ]  Yes [ ]  No

**If yes, complete the following**:

1. **Doctor / Hospital Name**: [DOCTOR / HOSPITAL NAME]
2. **Doctor / Hospital Phone**: [DOCTOR / HOSPITAL PHONE]
3. **Date of Visit**: [DATE]
4. **Time of Visit**: [TIME] [ ]  AM [ ]  PM
5. **Has this part of the employee’s body been injured before?** [ ]  Yes [ ]  No
	* + **If yes, when?** [DATE]

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| **WITNESSES** |

**Were there witnesses to the incident?** [ ]  Yes [ ]  No

**If yes, enter the witnesses’ names and contact info**:

1. **Full Name**: [NAME] **Phone**: [PHONE] **E-Mail**: [EMAIL]
2. **Full Name**: [NAME] **Phone**: [PHONE] **E-Mail**: [EMAIL]
3. **Full Name**: [NAME] **Phone**: [PHONE] **E-Mail**: [EMAIL]

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| **POLICE / EMERGENCY MEDICAL SERVICES** |

**Police Notified?** [ ]  Yes [ ]  No **If yes, was a report filed?** [ ]  Yes [ ]  No

**Was emergency medical treatment provided?** [ ]  Yes [ ]  No [ ]  Refused

**If yes, where was medical treatment provided?**

[ ]  On site [ ]  Hospital [ ]  Other: [OTHER]

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| **OFFICE USE ONLY** |

**Report received by**: [FULL NAME]

**Signature**: [\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_](https://esign.com/) **Date**: [DATE]

**Follow-up action taken**: [FOLLOW-UP ACTION TAKEN]