WORKPLACE INCIDENT REPORT FORM

EMPLOYEE INFORMATION

Employee Name: _____ **Job Title**: _____

Supervisor Name: _____

Signature: _____ **Date**: _____

INCIDENT DETAILS

Date of Incident: _____ **Time**: _____ ☐ AM ☐ PM

Location: _____

Incident Type: ☐ Injury ☐ Illness ☐ Near Miss ☐ Fire ☐ Equipment / Property Damage ☐ Violence ☐ Harassment ☐ Unsafe Conditions ☐ Other: _____

Describe the Incident:

Describe what could have been done to prevent the incident:

Has the employee's supervisor been notified about the incident? ☐ Yes ☐ No

PARTIES INVOLVED

1. **Full Name**: _____ **Phone**: _____ **E-Mail**: _____
   Address: _____
2. **Full Name**: _____ **Phone**: _____ **E-Mail**: _____
   Address: _____
3. **Full Name**: _____ **Phone**: _____ **E-Mail**: _____
   Address: _____
4. **Full Name**: _____ **Phone**: _____ **E-Mail**: _____
   Address: _____

INJURIES

Was anyone injured? ☐ Yes ☐ No
If yes, describe the injuries:

If the employee was injured, did they see a doctor? ☐ Yes ☐ No
If yes, complete the following:

1. **Doctor / Hospital Name**: _____
2. **Doctor / Hospital Phone**: _____
3. **Date of Visit**: _____
4. **Time of Visit**: _____ ☐ AM ☐ PM
5. **Has this part of the employee's body been injured before?** ☐ Yes ☐ No
    - **If yes, when?** _____

WITNESSES

Were there witnesses to the incident? ☐ Yes ☐ No
If yes, enter the witnesses' names and contact info:

1. **Full Name**: _____ **Phone**: _____ **E-Mail**: _____
2. **Full Name**: _____ **Phone**: _____ **E-Mail**: _____
3. **Full Name**: _____ **Phone**: _____ **E-Mail**: _____

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: _____

OFFICE USE ONLY

Report received by: _____

Signature: _____ **Date**: _____

Follow-up action taken: