

# INCIDENT REPORT

## PART 1 TO BE COMPLETED BY EMPLOYEE

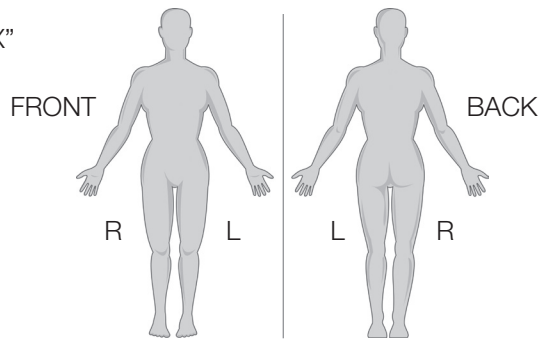
Employee Name \_\_\_\_\_ SSN \_\_\_\_\_  
Job Title \_\_\_\_\_ Department \_\_\_\_\_  
Date of Accident \_\_\_\_\_ Time of Accident \_\_\_\_\_ AM / PM

What was your job assignment at time of injury? \_\_\_\_\_

In the space below, please describe what happened. What were you doing? What equipment, machinery or substances were involved? How were you injured? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

State the nature of injury (*i.e., cut, bruise, burn, sprain, etc.*) and the specific part of body injured (*i.e., right knee, left index finger, etc.*)  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Mark part(s) of body injured with an "X"



Did you seek medical treatment?  Y /  N  
If yes, when/where? \_\_\_\_\_

Have you ever injured this body part(s) previously?  Y /  N  
If yes, give details (when/where/how/treating physician)  
\_\_\_\_\_

List all witnesses to the incident that you are aware of:  
\_\_\_\_\_

Did you report the incident to your supervisor  Y /  N  
If yes, who did you report to? \_\_\_\_\_ Date reported \_\_\_\_/\_\_\_\_/\_\_\_\_  
If no, why did you not report the incident? \_\_\_\_\_  
\_\_\_\_\_

### MEDICAL RELEASE:

I hereby authorize any medical provider to release all medical records pertaining to this injury and/or any prior treatment records to the areas of the body listed above, regardless of date of service.

Employee Signature \_\_\_\_\_ Date \_\_\_\_\_

# INCIDENT REPORT

## PART 2 TO BE COMPLETED BY IMMEDIATE SUPERVISOR & SAFETY DIRECTOR

IMMEDIATE SUPERVISOR TO COMPLETE

Employee Name \_\_\_\_\_ SSN \_\_\_\_\_

Date of Accident \_\_\_\_\_ Date Reported \_\_\_\_\_

Time of Accident \_\_\_\_\_ AM / PM

Date of Hire \_\_\_\_\_ Years on current job \_\_\_\_\_

Last Day Worked \_\_\_\_\_ Return-To-Work Date \_\_\_\_\_

Are pictures, sketches or video available?  Y /  N (Attach)

Witnesses to the incident?  Y /  N (Attach statements)

Was first-aid treatment given at the scene?  Y /  N / Offered but refused

Did employee seek medical treatment at an outside facility?  Y /  N

Incident Type (Fall, Slip/Trip, Caught In/Under/Between, Struck Against, etc.):

\_\_\_\_\_

Nature of Incident (Bruise, Burn, Cut, Fracture, Sprain, etc.):

\_\_\_\_\_

Body Part (Head, Back, Internal, Lower Limb, Upper Limb, Torso, etc. – LEFT/RIGHT)

\_\_\_\_\_

Equipment Involved: \_\_\_\_\_

Other factors involved (Failure to follow procedures, skill ability deficiency, horseplay, housekeeping, equipment or tools, etc.)

\_\_\_\_\_

\_\_\_\_\_

Supervisor Signature \_\_\_\_\_ Date \_\_\_\_\_

SAFETY DIRECTOR TO COMPLETE

What action have you taken and/or do you plan to take to prevent recurrence? Enumerate actions and star (\*) those already taken: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

What further recommendations or additional comments do you have?

\_\_\_\_\_

\_\_\_\_\_

Safety Director Signature \_\_\_\_\_ Date \_\_\_\_\_