

**EMPLOYEE**

**INCIDENT REPORT**

Use this form to report incidents or accidents involving an employee. This report must be filed within 24 hours upon the occurrence of the incident or accident.

Information about the Employee Involved in the Incident or Accident

|  |  |  |  |
| --- | --- | --- | --- |
| Full Name |  | | |
| Permanent Address |  | | |
| Employee Status |  | | |
| No. of Years Employed |  | | |
| Supervisor Name |  | | |
| Phone Numbers | Home: | Mobile: | Work: |

Information about the Incident or Accident

|  |  |
| --- | --- |
| Date and Time of Incident/Accident |  |
| Police Notified | ☐ Yes ☐ No |
| Location of the Incident/Accident |  |

|  |
| --- |
| Description of the Incident (What happened, how it happened, when it happened, and who was/were involved). Be specific as much as possible and use additional sheets, if necessary. |
|  |

|  |  |
| --- | --- |
| Were there witnesses to the incident/accident? | ☐ Yes ☐ No  If yes, please provide the witness details below. |
| Full Name |  |
| Permanent Address |  |
| Contact Details |  |

|  |  |
| --- | --- |
| Was the employee injured? | ☐ Yes ☐ No |
| Was medical treatment provided? | ☐ Yes ☐ No ☐ Refused |
| If yes, where was it given? | ☐ On Site ☐ Urgent Care ☐ Emergency ☐ Other |

|  |
| --- |
| Describe the injury and indicate the body part affected. Add any other information relevant to the injury. |
|  |

|  |  |
| --- | --- |
| Name of Attending Physician |  |
| Hospital Name and Address |  |
| Other Details |  |

Details of the Person Filing This Report

|  |  |
| --- | --- |
| Full Name |  |
| Position |  |
| Department |  |
| Date Filed |  |