Incident report

Employee/Injured Party

Name: _____ SSN: _____ DOB: _____

Address: _____

Home/Cell Phone: ( ) _____ Email: _____

Department Information

Supervisor Name/Phone #: _____

Department: _____

Job title: _____

Accident Information and Description

Date of Accident: Time of Accident: Location:

Weather Conditions: Witness(es):

Type of Injury (cut, bruise, sprain, etc): Body Parts Effected:

Have you had this condition prior to the incident? Yes No Maybe

Was Medical attention sought? Yes No If yes, Where?

Ambulance Transport Yes No

In your own words describe the accident including substances, materials or vehicles involved.

*Please provide any related documentation