Employee Incident Report

This form must be completed, reviewed with a supervisor, and submitted to HRSS within 24 hours.

Employee Name (last, fist): _____ EE#: _____ DOB: _____

Address: _____City: _____ State: ___ Zip: _____

Phone: _____ Job Title: _____ Hire Date: _____

Department: _____ Supervisor: _____

Date of Injury/Illness: _____ Time of Injury/Illness: _____Time Employee Began Work: _____

Location of Incident: _____ Who was Notified: _____

Date Employer Notified: _____ Last Date Worked: _____Date Returned to Work: _____

Body Part Injured: _____ If Fatal, Date of Death: _____

Describe incident (what happened, how the incident occurred, include details pertaining to equipment, environment, tasks, etc.)

_____

_____

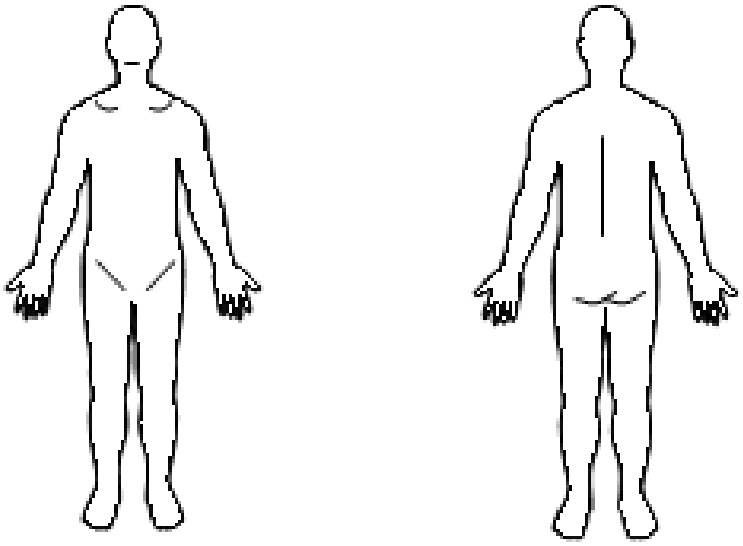
_____

_____

_____

Injury is a: New Injury ☐ Re-Injury ☐

Indicate on the Diagram the location of injury



Initial Treatment:

No Medical Treatment: ☐ Emergency Room: ☐

First Aid by Employer: ☐ Hospitalized Overnight: ☐

Minor Clinic/Hospital: ☐ Hospitalized >24 Hours: ☐

What was the cause of this incident?

_____

_____

_____

How could this incident have been prevented?

_____

_____

_____

Did anyone witness the incident? Yes ☐ No ☐

If yes, please provide the name and phone number of the witnesses.

_____

_____

_____

Do you have other employment? Yes ☐ No ☐

_____ _____

Employee Signature Date

Revised 12/27/17