

Employee Incident Report

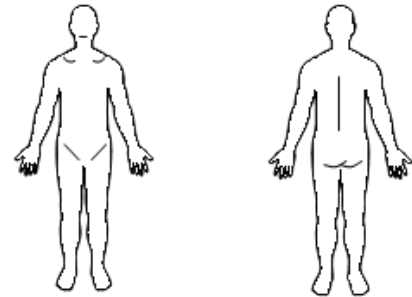
This form must be completed, reviewed with a supervisor and submitted to WCC within 24 hours.

Employee Name (last, first) _____ EE#/SS#: _____ DOB: _____
 Address: _____ Job Title: _____ Hire Date: _____
 City: _____ State: _____ Zip: _____ Department: _____
 Phone/Cell Number: _____ Supervisor: _____

Date of Injury/Illness: _____ Time Employee Began Work: _____ Time of Injury/Illness: _____
 Location of Incident: _____ Who was Notified? _____
 Date Employer Notified: _____ Last Work Day: _____ Date Returned to Work: _____
 Body Part Injured: _____ If Fatal, Date of Death: _____

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

Indicate on the Diagram the location of injury



Injury is a: New or Re-injury

Initial
 Treatment:

No Medical Treatment:
 First Aid by Employer:
 Minor Clinic/Hospital:

Emergency Room:
 Hospitalized Overnight:
 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 If yes, where? _____

 Employee Signature

 Date