WORKPLACE INCIDENT REPORT

Date of Report: _____, 20___

Person(s) Involved

Name: _____

Department: _____ Job Title: _____

Contact Information: _____

Name: _____

Department: _____ Job Title: _____

Contact Information: _____

Incident Details

Date of Incident: _____ Time: _____ ☐ AM ☐ PM

Location: _____

Description of Incident: _____
_____
_____
_____

Damages and Injuries

Were there any injuries? ☐ Yes ☐ No

Describe the injuries:
_____
_____
_____

Were there any property damages? ☐ Yes ☐ No

Describe the property damage:
_____
_____
_____

Witness(es)

Were there any witnesses to the incident? ☐ Yes ☐ No

Witness Name: _____

Contact Information: _____

Witness Name: _____

Contact Information: _____

Actions Taken

Was the police notified? ☐ Yes ☐ No

Was a police report filed? ☐ Yes ☐ No

Was medical treatment provided? ☐ Yes ☐ No

Describe the medical treatment:
_____
_____
_____

Describe any actions taken in response to the incident: _____
_____
_____
_____

Supporting Documents

Are supporting documents attached? ☐ Yes ☐ No

Describe the supporting documents:
_____
_____
_____

Acknowledgments

I, _____, confirm that the information provided in this Workplace Incident Report is true and accurate to the best of my knowledge.

Employee Signature: _____
Date: _____, 20___

I, _____, have reviewed this Workplace Incident Report and confirm that it accurately reflects the information provided by the employee and other witnesses.

Supervisor Signature: _____
Date: _____, 20___