WORKPLACE INCIDENT REPORT

Date of Report: _____, 20___

Employee(s) Involved

Name: _____ Gender: ☐ Male ☐ Female ☐ Non-binary

Date of Birth: _____, 20___ Date Hired: _____, 20___

Department: _____ Job Title: _____

Contact Information: _____

Name: _____ Gender: ☐ Male ☐ Female ☐ Non-binary

Date of Birth: _____, 20___ Date Hired: _____, 20___

Department: _____ Job Title: _____

Contact Information: _____

Incident Details

Date of Incident: _____, 20___ Time of Incident: _____ ☐ AM ☐ PM

Time Employee Began Work: _____ ☐ AM ☐ PM

Location: _____

What was the employee doing just before the incident occurred?

_____
_____
_____

Describe the incident:

_____
_____
_____

Injuries and Illnesses

Were there any injuries or illnesses? ☐ Yes ☐ No

Describe the injuries or illnesses:

_____
_____
_____

What objects or substances directly harm the employee?

_____

Medical Evaluation/Physician Information

Was the employee treated by a health care professional? ☐ Yes ☐ No

Name of Physician/Provider: _____

Name of Facility (if treatment was offsite): _____

Address of Facility: _____

Was the employee treated in an emergency room? ☐ Yes ☐ No

Was the employee hospitalized overnight as an in-patient? ☐ Yes ☐ No

Property Damages

Were there any property damages? ☐ Yes ☐ No

Describe the property damages:

_____
_____
_____

Other Actions Taken

Was the police notified? ☐ Yes ☐ No

Was a police report filed? ☐ Yes ☐ No

Describe any other actions taken in response to the incident:

_____
_____
_____

Witness(es)

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

Witness Name: _____

Contact Information: _____

Witness Name: _____

Contact Information: _____

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___