Incident/Accident Report

Immediate Supervisor should complete this form properly with worker input.
Please print clearly and report all incidents as soon as possible.

Injured Worker: _____

Occupation: _____

Where Injury Occurred:_____

Date/Time: _____(AM/PM)

Type of Injury: _____

Treatment: _____None_____1st Aid_____Doctor_____Hospital

Witnesses: _____
_____

Describe Incident/Injury:_____
_____
_____
_____
_____

Identify Cause: _____Work Habit_____Rule Violation_____Other (If Other, Describe)
_____

Caused by Faulty Equipment? If So, Identify:
_____

Did Previous Injury/Condition of Worker Contribute? Explain:
_____

If Incident Was Caused By A Person Not Employed By Us, Who?

Name: _____
Phone: _____
Address: _____

Action Taken to Prevent Similar Occurrence:

_____
_____
_____

Date:_____Injured Worker Signature:_____
(If Available)
Date:_____Supervisor's Signature:_____