

Employee Incident Report

I am reporting a work-related:

 Injury Illness

Employee Name:

Supervisor Name:

Date of Report:

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Job Title:

When was Supervisor Notified of Incident:

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Do you have Other Employment:

 Yes No

Location of Incident:

Date of Incident:

Time of Incident:

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Witnesses to Incident (if any):

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Incident Description (Describe the sequence of events and the resulting injury/illness):

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If Injured, What Body Part(s) was Affected:

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Was Medical Treatment Outside of First Aid Administered:

 Yes No

If Injured, Has This Body Part Been Injured Before:

 Yes No

What Could have Been Done to Prevent the Incident:

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This report is for information purposes only and is to be kept on file by the employer. Completing this form does not constitute filing a claim for workers' compensation. Workers' Compensation claims can only be submitted electronically through the carrier. By signing this form, you confirm that the information provided is true and complete to the best of your knowledge and understand that falsifying such information may be grounds for disciplinary action by the employer.

Employee Signature/Date

Supervisor Signature/Date