WORKPLACE INCIDENT REPORT FORM

INSTRUCTIONS

Fill out this form to report a workplace incident that resulted in injury, illness, or a near miss. Return completed form to:

THIS FORM SERVES TO DOCUMENT *select all that apply*

	LOST TIME / INJURY		FIRST AID		INCIDENT		CLOSE CALL		OBSERVATION

INDIVIDUAL AFFECTED To be filled in by person injured / involved, if possible.

NAME OF PERSON COMPLETING REPORT	SUPERVISOR NAME	DATE OF REPORT

PERSON(S) INVOLVED	EQUIPMENT / VEHICLES INVOLVED

INCIDENT DETAILS

LOCATION	DATE OF INCIDENT	TIME

WITNESSES

INCIDENT DESCRIPTION Describe tasks being performed and sequence of events. *Attach additional pages as necessary.*

Was event / injury caused by an unsafe act (activity or movement or an unsafe condition (machinery or weather)?

TO BE COMPLETED ONLY IF LOST TIME / INJURY OR FIRST AID WAS REQUIRED			
TYPE OF INJURY SUSTAINED:			
CAUSE OF LOST TIME / INJURY OR FIRST AID:			
Was medical treatment necessary?		If yes, name of hospital / physician:	
	YES	NO	

EMPLOYEE SIGNATURE	**DATE**	**SUPERVISOR SIGNATURE**	**DATE**

DISCLAIMER

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