

WORKPLACE INCIDENT REPORT FORM

Use this form to report accidents, injuries, medical situations, criminal activities, traffic incidents, or student behavior incidents. If possible, a report should be completed within 24 hours of the event.

Date of Report: _____, 20____

PERSON INVOLVED

Full Name: _____ Address: _____

Identification: Driver's License No. _____ Passport No. _____

Other: _____

Phone: (____) ____ - ____ E-Mail: _____

THE INCIDENT

Date of Incident: _____, 20____ Time: ____:____ AM PM

Location: _____

Describe the Incident: _____

INJURIES

Was anyone injured? Yes No

If yes, describe the injuries: _____

WITNESSES

Were there witnesses to the incident? Yes No

If yes, enter the witnesses' names and contact info: _____

POLICE / MEDICAL SERVICES

Police Notified? Yes No If yes, was a report filed? Yes No

Was medical treatment provided? Yes No Refused

If yes, where was medical treatment provided? On site Hospital Other: _____

PERSON FILING REPORT

Signature: _____ Date: _____

Print Name: _____

OFFICE USE ONLY

Report received by: _____ Date: _____, 20____

Follow-up action taken: _____

