



# Employee Incident Form

This report must be filed- even if no medical treatment is needed at this time

Form revised January-2005

## Section 1- Employee Information

Print Name		Social Security No.	Home Phone	
Date of Incident		Time of Incident	AM	PM
Job Title		Department		
Employee Address				
Number	Street	City	State	Zip
Phone:	Date of birth:	Sex	Male	Female
Does employee work elsewhere? Yes No If yes, Where?				
Company Address		Company Phone	Date Incident Reported To Supervisor	

If incident not reported within 24 hours...why late?

Name of Supervisor Incident Reported To:		Title		
Was injured employee performing regular job at the time of incident? Yes No				
Length of service with this employer:		On this Job:		
Time shift started:	AM	PM	Overtime	Yes No
Did employee leave work early due to incident		Yes	No	Time Left AM PM
Date return to work :		Time returned to work: AM PM		
Is this a recurrence of a previous related injury?		Yes	No	Original date of injury:
Fatality	Yes	No	If yes - Date of death	

## Section II - Injury Details And Employee Statements

Treating physicians name:	Facility name:
Address	Phone:
How was employee transferred:	
Part of body injured (i.e.- left thumb, right upper arm etc):	
Nature of injury (i.e. burn , cut, etc.):	
Where did the incident happen? ( exact physical location):	
Was a customer or vender involved?	
Witness ( Name and Phone #):	
Employee Statement (What happened,? What were you doing ? What tools/object involved? etc):	
Employees Signature:	Date:

**Section III- Machinery/Equipment Involved**

Was there equipment failure that caused the injury Yes No | If no - skip to Section IV

Manufacturer: | Age of Equipment:

Serial Number: | Model:

1. Function:

2. Location:

3. Has equipment been modified? Yes No If yes When? By Whom?

4. Did the equipment have guards in place? Yes No If no - Who removed them?

5. Was guarding properly Constructed Yes No

Installed Yes No

Adjusted Yes No

▪ If No to question 4 or 5... Explain:

6. Describe mechanical failure

**Training Involved**

7. Did employee receive specific training relating to safety and health on the job performed or equipment used? Yes No

8. Type of Training

9. Instructed by:

10. Date of Instruction: | Length of Training

**Specific Action That Will Be Taken Due To 1-10 Items Above**

Item #	Action to be taken	Person Responsible	Target Date

**Section IV- Employers Statement and Signatures**

Have witness statements been obtained? Yes No

Supervisor's/ Safety Manager's statement of incident, understanding of how incident occurred, if different from employee's statement, opinion on what additional actions should be considered, etc.

Completed by: | Title | Date

Reviewed by | Title | Date

Reviewed by Personnel | Date