

**College of Southern Idaho Head Start/ Early Head Start**  
**Incident Report – Staff**  
(Fax to Central Office within 24 hours)

**Name of Injured Staff** \_\_\_\_\_

Date Incident occurred \_\_\_\_\_ Time \_\_\_\_\_ a.m. or p.m.

At what time did you begin work? Time \_\_\_\_\_ a.m. or p.m.

Did you stop working on account of the incident? Yes  No

If so, on what date? \_\_\_\_\_ Time \_\_\_\_\_ a.m. or p.m.

What type of products or equipment was involved in the incident, if any? \_\_\_\_\_

\_\_\_\_\_

Describe in detail how the incident happened (Specify what was injured): \_\_\_\_\_

\_\_\_\_\_

Location of incident: \_\_\_\_\_

Was first aid administered? (Describe): \_\_\_\_\_

\_\_\_\_\_

Action taken by medical personnel, if required: \_\_\_\_\_

\_\_\_\_\_

(Workers Compensation - First Report of Injury or Illness must be completed by supervisor)

Diagnosis/Follow-up Plan: \_\_\_\_\_

\_\_\_\_\_

Employee's Signature \_\_\_\_\_

\_\_\_\_\_

Corrective action needed to prevent reoccurrence: \_\_\_\_\_

\_\_\_\_\_

Supervisor's Signature \_\_\_\_\_

Witnesses: Name \_\_\_\_\_

Phone \_\_\_\_\_