Incident Report – Staff

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 ______________________

________________________  ______________________

________________________  ______________________