INCIDENT REPORT

Section A. To be completed by the injured employee.

Employee name	Date of incident
Describe what you were doing and how the incident occurred.	

Section B. To be completed by supervisor, manager, safety professional, etc. (Please keep for your records.)

Time and date of incident	Date reported	Employee job title	Years of experience

Injury source
- ☐ Animal interaction
- ☐ Burn
- ☐ Caught in/between
- ☐ Chemical exposure
- ☐ Cut or laceration
- ☐ Material handling
- ☐ Motor vehicle accident
- ☐ Slip, trip, fall ☐ Heights
- ☐ Struck by or against
- ☐ Workplace violence
- ☐ Other:

Body part(s) affected
- ☐ Head
- ☐ Eye(s)
- ☐ Ear(s)
- ☐ Back/neck
- ☐ Arm/shoulder
- ☐ Hand/finger
- ☐ Chest/torso
- ☐ Leg/knee/ankle/foot
- ☐ Lung(s)

Relevant training received	
Subject	Date

Location of incident	Explanation of injury	Personal protective equipment (PPE) needed	
		Type	Used

Type of incident
- ☐ Near miss
- ☐ First aid
- ☐ Medical treatment
- ☐ Lost time

Witnesses (Print first and last name.)		
		☐ Yes ☐ No
		☐ Yes ☐ No
		☐ Yes ☐ No
		☐ Yes ☐ No
		☐ Yes ☐ No
		☐ Yes ☐ No

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