EMPLOYEE INCIDENT REPORT

This report is to be completed when an occupational illness or incident occurs. If an employee is injured or develops a job-related illness (developed gradually e.g., tendonitis) as a result of their employment they must complete and submit the "Incident Report"**. If the employee is unable to complete the form, the supervisor must complete on their behalf.**

EMPLOYEE: ****Please complete below. Upon completion, please give this form to your supervisor.**
****Sections in bold are required for initial submittal.**

*****EMPLOYEE COMPLETES THIS SECTION:** (**If the employee is unable to complete the form, the supervisor must complete on their behalf)**

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Social security number: ______________________

Name (print): ____________________________________ Sex ☐ Male ☐ Female

Home Address: ______________________ City: ________________ Zip: __________

Home Phone: ______________ **Work Phone:** ______________ **Cell Phone:** __________

Department: ______________________ Job Title: ________________________

Supervisor Name: ______________________ **Date/time notified:** ________________

Employment Type: ☐ full-time ☐ part-time ☐ regular ☐ temporary ☐ seasonal

Do you have other employment? ☐ yes ☐ no If so, where ______________________________

Date of Incident: ____________ Time of Incident: __________ **Time Shift Began**: __________

Location or address of incident: ____

State all parts of body and type of injuries involve (e.g. bruised right elbow)

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Describe how incident occurred:

____

____

Incident was reported to: ______________________________ **Date:** ______________

Do you require medical treatment for this injury?

☐ **No medical treatment** ☐ **Declined treatment at this time** ☐ **Treatment was/will be provided by:**

Name (facility or physician): ____

I, the injured employee, herein certify the information above is true and to best of my knowledge.

Date: ______________ **Signature of employee:** ______________________________