



EMPLOYEE INCIDENT/INJURY REPORT

INITIAL REPORT – THIS PAGE TO BE COMPLETED BY EMPLOYEE.

STAFF NAME:	SSN:	DOB:
HOME PHONE:	WORK PHONE:	
HOME ADDRESS:		
JOB TITLE:		DATE OF HIRE:
DATE OF INCIDENT/INJURY:	TIME OF INCIDENT/INJURY:	TIME WORK BEGAN:
Who else knows of this incident?:	Did you finish your shift?:	Who did you report this to?:
LOCATION INCIDENT/INJURY OCCURRED (ADDRESS):		

DESCRIBE THE INCIDENT/ACCIDENT IN DETAIL (WHO, WHAT, WHEN, WHERE, HOW):

CIRCLE ONE: A. INJURY INVOLVED B. INCIDENT REPORTED NO INJURY INVOLVED

DESCRIBE THE INJURY (PART OF BODY EFFECTED, ETC.):

EMPLOYEE SIGNATURE:	DATE:	TIME:
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If you are not obtaining treatment at this time, please note why here:

Do not feel necessary* Do not know where to go or what to do** Do not have time**

Other:

**Please report to HR if this status changes and/or your supervisor disagrees, **See HR*