TO BE FILLED OUT BY EMPLOYEE

Employee Name: _____ Department: _____

Classification: _____ Date of Hire: _____ Date of Birth: _____

Location of Accident: _____

Date of Occurrence: _____ Time: _____ AM PM

Accident Category (check one): ❑ Motor Vehicle ❑ Property Damage ❑ Personal Injury ❑ Other

TO BE FILLED OUT BY SUPERVISOR

What happened? *(Describe what took place or what caused you to make this*

Why did it happen? *(Get all the facts by studying the job and situation involved. Question by use of WHY?-WHAT?-WHERE?-WHEN?-HOW?)*

Was weather a factor? ❑ Yes ❑ No If yes, explain: _____

Personal protective equipment required? *(Protective glasses, safety shoes, safety hat, safety*

Was injured using required equipment? ❑ Yes ❑ No If no, explain: _____

Witnesses to accident: _____

Name of doctor and/or hospital consulted:

Lost time injury? ❑ Yes ❑ No

EMPLOYEE REMARKS:

It is understood that my signature on this form means only that I have had the opportunity to review this Incident Report. It does not mean that I agree with the findings.

Employee's Signature	*Date*