Accident/Injury/Incident Form

Full Name: _____ Date: _____

Address: _____ Phone Number: _____

Date of Birth: _____ Date of Hire: _____ Date of Incident: _____

Time of Incident: _____ Time Employee Began Work: _____

Exact Location of Incident: _____

Describe in detail what occurred: _____

_____

_____

_____

Any Witnesses? Yes_____ No_____ Name & Phone # of Witness:_____

_____

Were there any Injuries? Yes _____No ___(If no, you may sign and date at the bottom. If yes, proceed.)

Part of Body Affected (specify right, left, 1st, 2nd, etc): _____

Have you ever been under a doctor's care for the same or similar injury? If yes, please describe. _____

_____

Name of medical facility or doctor seen: _____

What machine, tool or object was most closely connected with the injury, if applicable? _____

_____

Were safeguards provided? Yes ____ No _____ Were safeguards used? Yes _____ No _____

Additional Comments: _____

_____

Signature:_____ Date: _____

*Return this form to Kimberly Thomson in Human Resources if a work-related injury/illness. For all other incidents, return to Shelley Monnig in Business Services.