Employee's Report of Incident Form

Instructions: Employees shall use this form to report all work related incidents (which could have caused an injury or illness) – *no matter how minor the incident may appear*. This helps us to identify and correct situations before they cause serious injuries. This form shall be completed by employees as soon as possible and given to their supervisor for further review and action.

I am reporting a work related: ☐ Incident ☐ Illness	
Your Name:	
Job title:	
Supervisor:	
Have you told your supervisor about this incident? Yes ☐ No ☐	
Date of incident:	Time of incident:
Names of witnesses (if any):	
Where, exactly, did this incident occur?	
What were you doing at the time of the incident?	
Describe step by step what led up to the incident. (continue on the back if necessary):	
What could have been done to prevent this incident?	
What parts of your body were affected?	
Did you see a doctor about this incident? Yes ☐ No ☐	
If yes, please provide Doctors name?	Doctor's phone number:
Date:	Time:
Has this part of your body been injured before? ☐ Yes ☐ No	
If yes, when?	Supervisor:
Your signature:	Date:

(Please Scan This Document to the Districts Workers' Compensation Representative Immediately)