

WORKPLACE INCIDENT REPORT

Date of Report: _____, 20____

Individual(s) Involved

Name: _____
Department: _____
Job Title: _____
Phone: _____
Email: _____

Name: _____
Department: _____
Job Title: _____
Phone: _____
Email: _____

Name: _____
Department: _____
Job Title: _____
Phone: _____
Email: _____

Incident Details

Date of Incident: _____, 20____
Time of Incident: _____

Type of Incident (check all that apply):

- ☐ Injury
- ☐ Property Damage
- ☐ Environmental
- ☐ Near Miss
- ☐ Vehicle Accident
- ☐ Other: _____

Description of Incident (include specific details, actions, and events leading up to the incident):



Location of Incident (be as specific as possible):

Witnesses (if applicable)

Name: _____

Phone: _____

Email: _____

Name: _____

Phone: _____

Email: _____

Injuries (if applicable)

Type of Injury: _____

Affected Body Part(s): _____

Immediate Treatment/First Aid Provided: _____

Treatment Facility: _____

Property Damage (if applicable)

Description of Damaged Property:

Estimated Cost of Damage: _____

Incident Investigation

Root Cause(s) of Incident:

Corrective Actions Taken:



Employee Statement

I, _____ (Employee Name), confirm that the information provided in this Workplace Incident Report is true and accurate to the best of my knowledge.

Employee Signature: _____

Date: _____, 20____

Supervisor's Statement

I, _____ (Supervisor Name), have reviewed this Workplace Incident Report and confirm that it accurately reflects the information provided by the employee and other witnesses.

Supervisor Signature: _____

Date: _____, 20____

