

Accident Incident Report Template

Accident / Incident Report Form Template

Employee
Name: _____ Title/Role: _____ Date of Report: _____

Employee
Signature: _____ Length of Time
In Current Role: _____ Date of Incident: _____

Location Of
Incident: _____ Time of Incident: _____

RESULT OF ACCIDENT/INCIDENT					INCIDENT INFORMATION	
HEAD	<input type="checkbox"/>			Left	Right	INCIDENT DESCREPTION
FACE	<input type="checkbox"/>	SHOULDER	<input type="checkbox"/>	<input type="checkbox"/>		
NECK	<input type="checkbox"/>	ARM PIT	<input type="checkbox"/>	<input type="checkbox"/>		
UPPER BACK	<input type="checkbox"/>	UPPER ARM	<input type="checkbox"/>	<input type="checkbox"/>		TASKS LEADING TO INCIDENT
LOWER BACK	<input type="checkbox"/>	LOWER ARM	<input type="checkbox"/>	<input type="checkbox"/>		
CHEST	<input type="checkbox"/>	ELBOW	<input type="checkbox"/>	<input type="checkbox"/>		
ABDOMEN	<input type="checkbox"/>	WRIST	<input type="checkbox"/>	<input type="checkbox"/>		ADDITIONAL INFO
PELVIS/GROIN	<input type="checkbox"/>	HAND	<input type="checkbox"/>	<input type="checkbox"/>		
LIPS	<input type="checkbox"/>	BUTTOCKS	<input type="checkbox"/>	<input type="checkbox"/>		
TEETH	<input type="checkbox"/>	HIP	<input type="checkbox"/>	<input type="checkbox"/>		OSHA RPORTING
TONGUE	<input type="checkbox"/>	THIGH	<input type="checkbox"/>	<input type="checkbox"/>		
NOSE	<input type="checkbox"/>	LOWER LEG	<input type="checkbox"/>	<input type="checkbox"/>		
FINGERS	<input type="checkbox"/>	KNEE	<input type="checkbox"/>	<input type="checkbox"/>		WITNESS NAME AND CONTACT
TOES	<input type="checkbox"/>	ANKLE	<input type="checkbox"/>	<input type="checkbox"/>		
OTHER:	<input type="checkbox"/>	EYES	<input type="checkbox"/>	<input type="checkbox"/>		
OTHER:	<input type="checkbox"/>	EARS	<input type="checkbox"/>	<input type="checkbox"/>		

VRIFICATION

Supervisor
Name: _____ Reported To: _____ Date of Report: _____

Supervisor
Signature: _____ Bureau: _____ Work Unit: _____

Additional Info: _____