INCIDENT REPORT FORM

Use this form to report any workplace accident, injury, incident etc. Return form to the Operations Manager.

THIS IS DOCUMENTING

☐ Medical/Injury ☐ Weather ☐ Incident ☐ Security ☐ Harassment

DETAILS OF PERSON INJURED OR INVOLVED (To be filled in by person injured/involved if possible)

Person completing report _____ Date _____/_____/_____

Person(s) involved _____

EVENT DETAILS

Date of Event _____/_____/_____ Location of Event _____

Time of Event _____ Witnesses: _____

DESCRIPTION OF EVENTS (Describe tasks being performed and sequence of events)

_____

_____

_____

_____

_____

WAS EVENT/INJURY CAUSED BY AN UNSAFE ACT (ACTIVITY OR MOVEMENT) OR AN UNSAFE CONDITION (EG. WEATHER)? Please explain.

_____

_____

_____

TO BE COMPLETED ONLY IF MEDICAL/INJURY OR FIRST AID WAS REQUIRED

Type of injury sustained	
Cause of injury	
Was medical treatment necessary? If yes, name hospital or physician	

_____

Employee Signature Employee Print Date

_____

Supervisor Signature Supervisor Print Date