

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