

Report of Incident

Please fill out completely to avoid fines in not reporting timely.

PERSONAL DATA

Name of Injured _____ Date of Birth _____

Address _____ Telephone _____

Social Security # _____ Length of Employment _____

Occupation _____ Days Worked Per Week _____

Wage/Hour _____ Wage/Day _____ Longevity Rate/Year _____

Name of Department/School _____

ACCIDENT DATA

Is injured losing any time from work? _____ If so, since when _____

Nature and location of injury _____

Equipment, tool or object involved _____

Location and address where accident occurred _____

Name and Address of Witnesses _____

Name and Address of Doctor and Hospital (If seen by) _____

ACCIDENT DESCRIPTION

In your own words, describe the accident including substances, materials or vehicles involved:

What can be done to prevent a recurrence of a similar accident:

Signature of Supervisor _____ Date _____

Signature of Injured _____ Date _____

Signature of Safety Officer _____ Date _____