EMPLOYEE INCIDENT REPORT

EMPLOYEE INFORMATION

Employee Name: _____Job Title: _____

Home Address/City/Zip Code: _____

Phone Number: __(_____ __)_____ Date of Birth:_____

Gender:☐ Male ☐ Female Date of Hire:_____ Social Security #_____

Start Time:_____End Time:_____ Work Site:_____

# of Hours Worked Daily:_____ # of Days Weekly:_____ # of Hours Weekly:_____

INJURY/ILLNESS INFORMATION

Type of Incident: ☐Injury ☐First Aid ☐Near Miss

Date of Injury/Incident: _____ Time: _____ Date Reported: _____

How did you report the injury/incident?☐In person ☐Phone ☐Other: _____

Did anyone witness the injury?☐Yes ☐No If so, Who:_____

Was anyone else injured?☐Yes ☐No If so, Who:_____

Where did injury/incident occur? (Be specific, including building & room number, if applicable)

_____

What were you doing when the injury/incident occurred? (state equipment, materials and/or chemicals)

_____

Describe how the injury occurred: (Example: I was walking down the stairs, tripped & fell injuring right knee on the cement; I was lifting a box, felt sharp pain in lower back.)

_____

_____

What body part(s) were injured?_____

Have you ever had previous trouble with this part of your body?_____

Was there anything that could have been done to prevent the injury?_____

MEDICAL TREAMENT

Are you seeking medical treatment at this time?☐No ☐Yes (if no fill out refusal of treatment)

If yes please indicate where you are being referred to:_____

EMPLOYEE SIGNATURE

This is an accurate statement, in my own words, which describes my accident and/or injuries.
Warning: Any person who makes a false or fraudulent written or oral statement for the purpose of obtaining workers' compensation benefits or payments is guilty of a felony. Penalties include fines, imprisonment or both.

_____ _____

(Signature) (Please Print Name)

Date_____

Form #100 (Revised 8/1/2016)