

# EMPLOYEE'S INCIDENT REPORT

## INCIDENT DATA (Please Print)

Date of incident: \_\_\_\_/\_\_\_\_/\_\_\_\_ Date requested medical attention: \_\_\_\_/\_\_\_\_/\_\_\_\_  
Time of Incident: \_\_\_\_\_ am/pm (circle) Where did it happen? \_\_\_\_\_

What equipment or chemicals were you using when this happened? \_\_\_\_\_  
What work process were you performing? (i.e., food service, custodial, teacher, teacher aide, transportation, maintenance, etc.) \_\_\_\_\_

What were you doing specifically when the injury/illness occurred? (i.e., lifting, walking, running, driving, etc.)  
\_\_\_\_\_

Did you receive training on how to properly perform the work you were doing? Yes \_\_\_\_\_ No \_\_\_\_\_  
Did you receive training on how to avoid injuries while performing this work? Yes \_\_\_\_\_ No \_\_\_\_\_  
Who conducted this training? \_\_\_\_\_ When? \_\_\_\_\_  
Describe in detail the sequence of events and include objects, equipment or people that directly caused your injury:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Did you report this injury/illness to your Supervisor?  Yes  No If yes, date: \_\_\_\_\_  
If no, why not? \_\_\_\_\_

Give name(s) of witness(es) to your injury/illness: \_\_\_\_\_

Could this injury have been prevented? How?  
\_\_\_\_\_

### What part(s) of your body were hurt?

(Mark the appropriate blank or write in **R** for Right, **L** for Left when applicable.)

**Head:** \_\_\_Face \_\_\_Skull \_\_\_Neck \_\_\_Mouth \_\_\_Nose \_\_\_Eye \_\_\_Ear

**Trunk:** \_\_\_Chest \_\_\_Shoulder \_\_\_Upper back \_\_\_Lower back \_\_\_Abdomen \_\_\_Hip

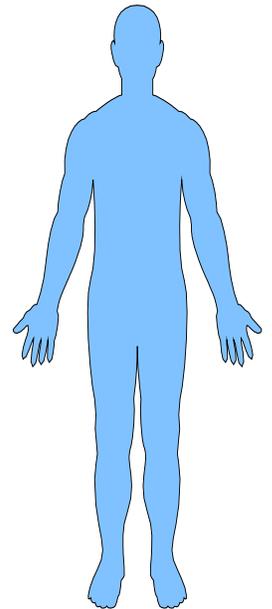
**Arm:** \_\_\_Upper \_\_\_Elbow \_\_\_Wrist \_\_\_Hand \_\_\_Palm \_\_\_Finger

**Leg:** \_\_\_Foot \_\_\_Knee \_\_\_Thigh \_\_\_Ankle \_\_\_Calf \_\_\_Toe

**Other:** \_\_\_\_\_

### What type of injury/illness do you have? (Check all that apply)

- Abrasion (scrape)       Strain/Sprain       Bruise       Poisoning (Ivy, Oak, Other)
- Fracture                 Cut/Puncture       Crush         Burn
- Respiratory             Amputation         Swelling      Dislocation
- Other: \_\_\_\_\_



Please circle the injured or affected area on the right.

All the information I have provided in this report is true and correct. I understand that providing false or misleading information or omission of information on this report or any other form related to this injury may result in termination of my employment.

Employee Signature: \_\_\_\_\_ Date: \_\_\_\_\_ Witness: \_\_\_\_\_