Incident Report Form

Please complete this form and return to main office within 24 hours of the incident.

EMPLOYEE INFORMATION

EMPLOYEE COMPLETES THIS SECTION

Job location: _____ Employee ID: _____

Employee name (print): _____ Gender: Male Female

Address: _____ City: _____ State: _____ Zip: _____

Phone: _____ Work Phone: _____

Department: _____ Title Code/Job Title: _____

Work Hours: _____ Hours Worked Per Week: _____

Employment Type: Full-Time Part-Time Career Limited Appointment Volunteer

INCIDENT INFORMATION

Date of Incident: _____ Time of Incident: _____ : _____ AM PM

Location of Incident: _____

Incident Address: _____ City: _____ State: _____ Zip: _____

Precautions taken:

Describe how the incident occurred.

Was incident reported? Yes No If "Yes", to whom? _____ Date Reported: _____

Was there a witness? Yes No Unknown

Witness #1 (Full Name): _____ Phone: _____

Witness #2 (Full Name): _____ Phone: _____

Witness Statement:

Employee signature: _____ Date: _____

Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

SUPERVISOR SECTION

Supervisor Name: _____ Work Phone: _____ Work Email: _____

Employee name: _____ Police report: _____

Was prior approval of work given? Yes No

Was employee escorted? Yes No Unknown If “Yes”, Name of Escort: _____

Was there equipment involved? Yes No If “Yes”, what was the equipment? _____

What action will be taken to prevent recurrence? _____

Comments: _____

Type of work being performed:

Additional Comments:

Name: _____ Title: _____

Signature: _____ Date: _____