WORKERS' COMPENSATION INCIDENT REPORT

(No Medical Treatment Required)

Name: _____ **Age:** _____ **Employee ID No.** _____

Address: _____
Street City State Zip

Home Phone: _____ **Cell Phone:** _____

Job Title: _____

Agency Name: _____

Agency Address: _____
Street City State Zip

Date of Accident: _____ **Time of Accident:** _____

Location Where Incident Occurred: _____

Description of Incident: _____

_____

Body Parts Injured: _____

Personal Protective Equipment (PPE) worn? Yes ☐ No ☐ N/A ☐

If "YES", what type of Personal Protective Equipment was used? _____

_____

Seat Belt Properly Used Yes ☐ No ☐ N/A ☐

Opinion of Supervisor ☐ **Preventable** ☐ **Non-Preventable**

Witness of Accident	Address
_____	_____
_____	_____

Injured Employee Signature: _____

Supervisor (Please Print): _____

Supervisor Signature: _____

Supervisor Phone Number: _____

Date Completed: _____