Incident Report Form

Employee Details

Name: _____ Occupation: _____

Department: _____ Date of Report: ____ /____ /____

Incident Details

Date: _____ Time: _____ Date reported: ____ /____ /____

Location: _____Witness Name: _____

Reported to: _____

Description of Incident: (what happened, or in the case of a near miss, what could have happened?)

_____

_____

Injury Type

☐Contusion/Crush	☐Burn	☐Dislocation	☐Internal Injury
☐Amputation	☐Laceration	☐Concussion	☐Sprain/Strain
☐Superficial Injury	☐Foreign Body	☐Fracture	☐Dermatitis

Location of Injury

☐Head/Face	☐Eye	☐Internal Organs	☐Hand/fingers
☐Shoulder/Arms	☐Trunk (other than back)		☐Hip/Leg
☐Foot/Toes	☐Back	☐Other:	

Results of Accident

_____

Lost time injury: Y / N No. of days: _____ days Workers' Compensation: Y / N

Treatment Received: ☐First Aid ☐Hospital ☐Doctor

First Aid Kit Used: Y / N Defibrillator Used: Y / N Treatment Items need Inspection/Replacement: Y / N

Damage to Equipment/Buildings/Vehicles etc.

What was damaged? _____

Extent of damage? _____

Contributing Factors

What were the Contributing Factors (if any)? _____

Corrective Actions

Immediate Actions: _____

Control Measures: (prevent from happening again)

_____

Recommendations for action: _____

Who is to implement these controls/corrective actions? _____

Date by which action is to be taken: ____ /____ /____

Signatures

Employee Name: _____ Employee Signature: _____

HS Rep Name: _____ HS Rep Signature: _____

Manager Name: _____ Manager Signature: _____

Director Name: _____ Directors Signature: _____

Investigators Name: _____ Investigators Signature: _____