Employee Incident Report

Employees must complete this Incident Report when they sustain a work-related injury or illness. Incident Reporting ensures there is a record of the incident on file and helps us provide a safe work environment. If medical treatment is required also fill out the DWC-1 form. **Please return form to HR within 24 hours.**

Employee Name (Please Print)	**Cell Phone**	**Work Phone**
Home Street Address		
City, State, Zip Code	**Job Title**	
Location Name	**Supervisor Name**	**Supervisor Phone**

Date of Incident	**Time of Incident**	**Time Began Work**	**Time Stopped Work**	**Finished Shift** ☐ **Yes** ☐ **No**
Location of Incident				
How did the incident occur? Describe the activity and any tools or equipment you were using. Be specific. Use additional page(s) if necessary.				

List the body part(s) injured and type of injury. Mark all that apply.

☐ **HEAD** ☐ **EYE** ☐ R ☐ L ☐ **ARM** ☐ R ☐ L ☐ **KNEE** ☐ R ☐ L ☐ **HIP** ☐ R ☐ L

☐ **FACE** ☐ **RIBS** ☐ R ☐ L ☐ **ELBOW** ☐ R ☐ L ☐ **ANKLE** ☐ R ☐ L ☐ **THIGH** ☐ R ☐ L

☐ **NOSE** ☐ **UPPER BACK** ☐ **LOWER BACK** ☐ **HAND** ☐ R ☐ L ☐ **FOOT** ☐ R ☐ L

☐ **NECK** ☐ **LEG** ☐ R ☐ L ☐ **SHOULDER** ☐ R ☐ L ☐ **FINGER – IDENTIFY**_____

☐ **TOE IDENTIFY**_____ ☐ **OTHER** _____

Date Incident Reported	**To Whom Did You Report It?**
Name of Witnesses (if applicable)	

☐ I **DO NOT** wish to seek medical treatment and I will notify Human Resources if I change my mind.

☐ I **DO** wish to seek medical treatment and want to file a workers' compensation claim.

By signing this form, the employee certifies that the information the employee has provided is true to the best of the employee's knowledge.

Employee's signature:_____ Date Signed:_____