Witness Incident Report

Employees must complete this Incident Report when they witness 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. **Please return form to HR within 24 hours.**

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

Name of Employee Injured	**Date of Incident**	**Time of Incident**
Location of Incident		
How did the incident occur? Describe the activity and any tools or equipment used. Be specific. Provide any important information relating to the incident.		

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** ____________________________

Name of other Witnesses (if applicable)

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 Witness's Signature:________________________________Date Signed:____________

Revised December 2020