

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 <input type="checkbox"/> Yes <input type="checkbox"/> No
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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?
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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: _____