Incident Report Form

Name of Injured Employee/Volunteer First_____ Last ____December 26, 2024_____
Job Title _____ Male / Female DOB: _____
Department _____
Phone Number _____ Email _____

Time of Accident _____ Date of Accident _____
Location of Accident _____
Name of Witness(s) A: _____
B: _____

Description of Accident
_____
_____
_____
_____

Vehicular (involved, yes/no) Type _____ *Driver* _____
Required Hospital / Physician / EMS (*yes/no)* _____ Dr./ Nurse seen _____
Contact Information _____

Task Being Performed when accident occurred? _____

Equipment, Tools, Personal Protective Equipment, Procedures Being Used
_____
_____

Description of Injury/Illness (include accident type, injury type and body part injured)
_____
_____

Describe All Contributing Factors _____
Description of Work Area _____

Injured Employee/Volunteer's Account of Accident
_____
_____

Witness's Account of Accident: (Name, title, address, phone number)
_____
_____
What Were the Basic Causes of the Accident (usually multiple causes)?
_____
_____
Corrective Measures to be Implemented to Prevent Similar Reoccurrence
_____

Investigator's Name _____
Date of Investigation _____
Date Reported to Insurance Company _____

Disclosure: source of content for incident report, *Nonprofit Risk Management Center*