

# **INCIDENT REPORT**

(Please Answer Every Question)

**Your Name:** \_\_\_\_\_  
First Middle Last

**Your Employer's Name:** \_\_\_\_\_

**Your Address:** \_\_\_\_\_  
Street City State Zip

**Telephone Number:** \_\_\_\_\_ **Social Security:** \_\_\_\_\_ **Age:** \_\_\_\_\_

**Date of Birth:** \_\_\_\_\_ **Job Title:** \_\_\_\_\_ **Length of Employ:** \_\_\_\_\_

**Date of Injury:** \_\_\_\_\_ **Time of Injury:** \_\_\_\_\_ am \_\_\_\_\_ pm

**Describe how you were injured:** \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

**Describe the type of injury (ex. bruise, contusion, strain, sprain, etc.)** \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

**Did your injury occur from one specific incident?** \_\_\_\_\_ **If yes, explain in detail.** \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

**Did your injury develop gradually over a period of time?** \_\_\_\_\_ **If yes, indicate period of time:**

**From:** \_\_\_\_\_ **To:** \_\_\_\_\_ **Describe how injury developed.** \_\_\_\_\_  
Date Time Date Time

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Is there any way, other than described above, that you possibly could have injured yourself?**  
**Yes** \_\_\_\_\_ **No** \_\_\_\_\_ **If so, please give details.**

\_\_\_\_\_  
\_\_\_\_\_

**Explain what caused your injury: (Example: What caused you to fall).** \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

**If you were lifting or moving an object when you were injured, describe the object:** \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

**Give the approximate weight of the object:** \_\_\_\_\_

## **Incident Report**

**Page 2:**

**Describe the position you were in when you were injured:** (Example: Sitting, Standing, Squatting, Bending).

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**When did you first realize you were injured?** \_\_\_\_\_ **When did you first feel the**  
Date Time

**pain?** \_\_\_\_\_ **Who at work, did you first tell about your injury?** \_\_\_\_\_  
Date Time

\_\_\_\_\_ **When did you tell them?** \_\_\_\_\_ **When did you**  
Date Time

**first tell your immediate supervisor of your injury?** \_\_\_\_\_ **Name of your supervisor**  
Date Time

**you reported your injury to :** \_\_\_\_\_ **If injury was not reported**

**to your supervisor on the date you were injured, state the reason it was not reported:** \_\_\_\_\_

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**Name(s) of person(s) who witnessed your injury:** \_\_\_\_\_

**List parts of your body injured:** \_\_\_\_\_

**List type of injury (ex. bruise, contusion, strain, sprain)** \_\_\_\_\_

**Names & Addresses of Physician(s) who have treated you for this injury:**

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**Name & Address of Hospital:** \_\_\_\_\_

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**Have you lost time from work due to this injury?** \_\_\_\_ **If so, indicate the first day you missed from**  
Yes No

**work?** \_\_\_\_\_ **If so, indicate the date you returned to work after this injury?** \_\_\_\_\_

**Additional Remarks:** \_\_\_\_\_

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**\* I certify that the answers given to the questions on both pages (2) of this Incident Report are correct and accurate to the best of my ability and recollection.**

\_\_\_\_\_  
**Employee Signature**

\_\_\_\_\_  
**Date**