

**EMPLOYEE INCIDENT FORM**  
**Complete All Entries**



Please complete in detail. Use additional paper if necessary.

Name: \_\_\_\_\_ Date of Incident: \_\_\_\_\_

Supervisor: \_\_\_\_\_ Time of Incident: \_\_\_\_\_ a.m./p.m.

Where did the accident/incident occur? \_\_\_\_\_

Witnesses (state names): \_\_\_\_\_

Did you leave your work day earlier than scheduled to see the doctor? \_\_\_\_ Yes \_\_\_\_ No

Body Part Injured and Nature of Injury (describe in **DETAIL** the exact symptoms and parts of body injured. Use back of form to show where on your body, the injury occurred)

Type of pain : \_\_\_\_ Dull \_\_\_\_ Ache \_\_\_\_ Severe \_\_\_\_ Sharp

Persons notified or contacted (include name, title, date, time).

Describe in **DETAIL** how the accident/incident occurred:

Cause of the accident/incident: \_\_\_\_\_

Has this part of your body been injured before? \_\_\_\_ Yes \_\_\_\_ No When?

Your recommendation to prevent similar accident/incidents in future: \_\_\_\_\_

1<sup>st</sup> Aid provided? \_\_\_\_ Yes \_\_\_\_ No

Have you been seen by a medical professional? \_\_\_\_ Yes \_\_\_\_ No

If not yet seen by a medical professional, do you intend to seek medical attention? \_\_\_\_ Yes \_\_\_\_ No  
/Stating "No" does not prevent you from seeking treatment any time later if the need related to this incident arises/

If yes to either, name of medical professional: \_\_\_\_\_

Location: \_\_\_\_\_ Phone # \_\_\_\_\_

(You can choose any doctor for your treatment)

Has time been lost from work? \_\_\_\_ Yes \_\_\_\_ No      Modified work? \_\_\_\_ Yes \_\_\_\_ No

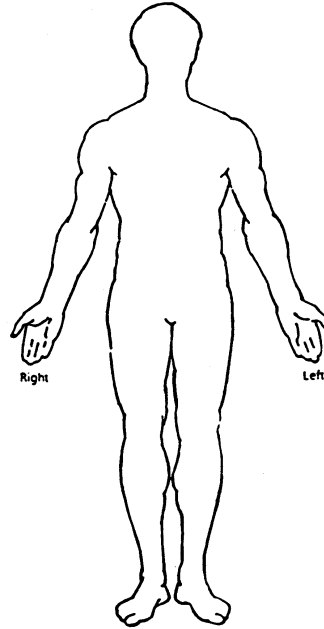
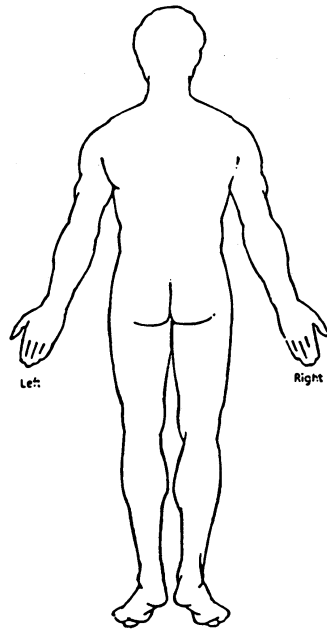
Signature of Employee: \_\_\_\_\_ Date: \_\_\_\_\_

**Using the symbols given below, mark the areas on your body where you feel the described sensations. Include all affected areas.**

Aching	Numbness	Pins and needles	Burning	Stabbing	Other
HHHH	=====	OOOOOO	x x x x	/////	!!!!

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