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: __________________________

_________________________________________________________________________________________

_________________________________________________________________________________________

1st 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)

JANUS YOUTH PROGRAMS 707 NE Couch Street Portland OR 97232 Form Revised: 03/16/2016
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  = = = =  O O O O O O  x x x  /////  !!!!