Employee Incident Report

This form must be completed, reviewed with a supervisor and submitted to WCC within 24 hours.

Employee Name (last, first, middle) _____ EE#SS# _____

Department _____ Job title _____ Hire Date _____

Supervisor _____ Shift ☐ 1 ☐ 2 ☐ 3 ☐ other

Date of Incident _____ Time (am/pm) _____

Day Occurred ☐ S ☐ M ☐ T ☐ W ☐ TH ☐ F ☐ S

Location of Incident _____ Who was Notified? _____

Describe incident (describe what happened, how the incident occurred, include details pertaining to equipment, environment, tasks etc.)

_____

_____

_____

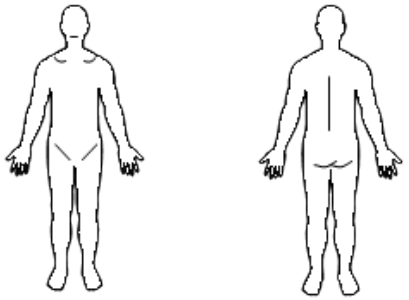
_____

_____

_____

_____

Indicate on the Diagram the location of injury



Body Part Injured _____

Injury is a: ☐ New or ☐ Re-injury

Was first aid administered? ☐ Yes ☐ No

If yes, where? _____

What was the cause of this incident? _____

How could this incident have been prevented? _____

_____

Did anyone witness the incident? ☐ Yes ☐ No

(Names) _____

Do you have other employment? ☐ Yes ☐ No

If yes, where? _____

_____ _____

Employee Signature Date