Accident / Incident Report Form

EMPLOYEE NAME: ______________________ TITLE / ROLE: ______________________ DATE OF REPORT: ______________________

EMPLOYEE SIGNATURE: ______________________ LENGTH OF TIME IN CURRENT ROLE: ______________________ DATE OF INCIDENT: ______________________

LOCATION OF INCIDENT: ____ TIME OF INCIDENT: ______________________

RESULT OF ACCIDENT / INCIDENT				
			LEFT	RIGHT
HEAD				
FACE		SHOULDER		
NECK		ARM PIT		
UPPER BACK		UPPER ARM		
LOWER BACK		LOWER ARM		
CHEST		ELBOW		
ABDOMEN		WRIST		
PELVIS / GROIN		HAND		
LIPS		BUTTOCKS		
TEETH		HIP		
TONGUE		THIGH		
NOSE		LOWER LEG		
FINGERS		KNEE		
TOES		ANKLE		
OTHER:		EYES		
OTHER:		EARS		

INCIDENT INFORMATION	
INCIDENT DESCRIPTION	
TASKS LEADING TO INCIDENT	
ADDITIONAL INFORMATION	
OSHA REPORTING	
WITNESS NAME AND CONTACT	

VERIFICATION

SUPERVISOR NAME: ______________________ REPORTED TO: ______________________ DATE OF REPORT: ______________________

SUPERVISOR SIGNATURE: ______________________ BUREAU: ______________________ WORK UNIT: ______________________

ADDITIONAL INFORMATION: ____