



Serving Physicians Since 1980



## INCIDENT REPORT

Name: \_\_\_\_\_ SS#: \_\_\_\_\_

Date of Injury: \_\_\_\_\_ Date reported & to whom: \_\_\_\_\_

Age: \_\_\_\_\_ Sex: \_\_\_\_\_ Occupation: \_\_\_\_\_ Dept: \_\_\_\_\_

Where did the injury occur? \_\_\_\_\_

Describe the injury in detail: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

What caused the injury? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Was first aid required: \_\_\_\_\_ If so, what: \_\_\_\_\_

Was hospital/doctor treatment required? \_\_\_\_\_ If so, what: \_\_\_\_\_

\_\_\_\_\_

Will injury cause loss of time? \_\_\_\_\_ If so, for how long? \_\_\_\_\_

When is the employee expected to return to work? \_\_\_\_\_

Name of the person giving initial treatment: \_\_\_\_\_

Name(s) of any witnesses: \_\_\_\_\_

What has been done to prevent a recurrence? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Date prepared: \_\_\_\_\_ By Whom: \_\_\_\_\_ Title: \_\_\_\_\_

Date: \_\_\_\_\_ Supervisor's signature: \_\_\_\_\_