Incident Reporting Form

Use this form to report any workplace accident, injury, incident, close call or illness.
Return completed form to the Operations Supervisor, or Management.

This is documenting an:

Lost Time/Injury ☐ First Aid ☐ Incident ☐ Close Call ☐ Observation ☐

Details of person injured or involved (to be filled in by person injured / involved if possible)

Person Completing Report: _____ Date: _____
Person(s) Involved: _____
Equipment or Truck ID: _____

Event Details

Date of Event: _____ Location of Event: _____

Time of Event: _____ Witnesses: _____

Description of Events (Describe tasks being performed and sequence of events):

_____
_____
_____
_____

*If more space is required please use the back of this sheet

Was event / injury caused by an unsafe act (activity or movement) or an unsafe condition (machinery or weather)? Please explain:

_____
_____

TO BE COMPLETED ONLY IF LOST TIME/INJURY OR FIRST AID WAS REQUIRED	
Type of injury sustained:	
Cause of lost time/ injury or first aid:	
Was medical treatment necessary?	Yes____ No____ If yes, name of hospital or physician:

Signature of Employee: _____ Date: _____

Signature of Supervisor: _____ Date: _____