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:_____