WORKERS' COMPENSATION INCIDENT REPORT

(No Medical Treatment Required)

Name:______________________________ **Age:**________ **Employee ID No.** __________________

Address:____

Street **City** **State** **Zip**

Home Phone:_______________________________ **Cell Phone:**____________________________________

Job Title:____

Agency Name:____

Agency Address:____

Street **City** **State** **Zip**

Date of Accident:_________________________________ **Time of Accident:**________________________

Location Where Incident Occurred:____

Description of Incident:____

____

Body Parts Injured:____

Personal Protective Equipment (PPE) worn? **Yes** ☐ **No** ☐ **N/A** ☐

If "YES", what type of Personal Protective Equipment was used?________________________________

____

Seat Belt Properly Used: **Yes** ☐ **No** ☐ **N/A** ☐

Opinion of Supervisor ☐ **Preventable** ☐ **Non-Preventable**

Witness of Accident	**Address**
______________________________	______________________________
______________________________	______________________________

Supervisor (Please Print):____

Supervisor Signature:____

Supervisor Phone Number:____

Date Completed:____