Clear Form

SAMPLE INCIDENT REPORT

This form must be completed within 24 hours of the Supervisor learning of the incident

☐ Injury: ☐ First Aid ☐ Medical Aid		☐ No Injury ☐ Hazardous Situation	
THIS SECTION TO BE COMPLETED BY THE EMPLOYEE			
Who was hurt? ☐ Employee ☐ Visitor ☐ Contractor ☐ Other	Last Name:	First Name:	Initial:
	Job Title:	Department:	Phone or Extension:
	Supervisor:	Date & Time of Incident:	Date Reported:
Description of Incident:			Type of Incident: ☐ Slip*, trip or fall ☐ Struck by / against object ☐ Over exertion ☐ Repetitive strain ☐ Electrical contact ☐ Exposure to hazardous material ☐ Other (describe)
*If this was a SLIP, describe footwear:			
Witnesses to the incident: (names and phone numbers)			
Did you see a medical professional? ☐ Yes ☐ No If YES, please provide name, address and phone number:		Treatment of Injury: ☐ First Aid ☐ Walk-in Clinic ☐ Family Doctor ☐ Emergency Room ☐ Other (describe)	
THIS SECTION TO BE COMPLETED BY THE SUPERVISOR			
Contributing Factors: What conditions contributed to the incident? ☐ Unsafe equipment ☐ Inadequate illumination ☐ Not or improperly guarded ☐ Hazardous environment ☐ Insufficient training ☐ Improper position/posture ☐ Insufficient care ☐ Infraction or unsafe practice ☐ Failure to use PPE ☐ Operating without authority ☐ Failure to lockout ☐ Other (Explain)			
Explanation of contributing factors:			
Details of property damage (if any):			
To your knowledge, has the employee had a previous similar injury or has this similar hazard been reported before? ☐ Yes ☐ No ☐ N/A			
Explanation of corrective measures:			
Signature of Employee Reporting Incident:	Date:	Signature of Supervisor:	Date: