**INCIDENT REPORT FORM**

Employee Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
Title: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Report: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
Employee Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
Length of Time in Current Role: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
Location of Incident: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Incident: \_\_\_\_\_\_\_\_\_\_\_\_

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Incident information** | | | | | | | |
| Head |  |  | **Left** | **Right** |  | Incident description |  |
| Face |  | Shoulder |  |  |
| Neck |  | Arm pit |  |  |
| Upper back |  | Upper arm |  |  |
| Lower back |  | Lower arm |  |  | Tasks leading to incident |  |
| Chest |  | Elbow |  |  |
| Abdomen |  | Wrist |  |  | Additional information |  |
| Pelvis / groin |  | Hand |  |  |
| Lips |  | Buttocks |  |  | Osha reporting |  |
| Teeth |  | Hip |  |  |
| Tongue |  | Thigh |  |  | Witness name and contact |  |
| Nose |  | Lower leg |  |  |
| Fingers |  | Knee |  |  |  |
| Toes |  | Ankle |  |  |
| Other: |  | Eyes |  |  |  |
| Other: |  | Ears |  |  |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Verification** | | | | | |
| Supervisor name: |  | Reported to: |  | Date of report: |  |
| Supervisor signature: |  | Bureau: |  | Work unit: |  |
| Additional information: |  | | | | |