

Blank Workplace Injury Incident Report Form

Date of Incident

Time of Incident

Location

Enter location

Employee Information

Name

Employee name

Employee ID

Employee ID

Department

Department

Job Title

Job title

Incident Details

Describe the Incident

Describe what happened

Describe the Injury

Describe type and extent of injury

Was medical attention required?

Select

If yes, specify

Details of medical attention

Witness Information (if any)

Witness Name

Name

Contact

Contact

Additional Notes

Any additional details

Report Completed By

Your name

Date