

Occupational Injury Incident Report Form

Employee Information

Name

Employee ID

Department

Job Title

Supervisor

Incident Details

Date of Incident

Time of Incident

Location

Describe the Incident

Injury/Illness Details

Nature of Injury/Illness

Part of Body Affected

Was First Aid Given?

Select

If Yes, By Whom and What Treatment

Witness Information

Witness Names (if any)

Additional Information

Additional Comments/Remarks

Report Completed By

Date