Workplace Accident Incident Report Form

1. Employee Information

Full Name

Job Title/Position

Employee ID

Department

2. Incident Details

Date of Incident

Time of Incident

Location of Incident

Description of Incident

Cause of Incident (if known)

3. Injury/Illness Details

Describe Injury/Illness (if any)

Treatment Provided

4. Witnesses (if any)

Name(s) & Contact Information

5. Additional Information

Action Taken/Recommendations

Other Comments

6. Signatures

Employee Signature / Date

Supervisor Signature / Date