WORKERS' COMPENSATION INCIDENT REPORT
(No Medical Treatment Required)

Name: _____ Age: _____ Employee ID No. _____

Address: _____

Street City State Zip

Home Phone: _____ Cell Phone: _____

Job Title: _____

Agency Name: _____

Agency Address: _____
Street City State Zip

Date of Accident: _____ Time of Accident: _____

Location Where Incident Occurred: _____

Description of Incident: _____
_____

Body Parts Injured: _____

Personal Protective Equipment (PPE) worn? Yes No N/A

If "YES", what type of Personal Protective Equipment was used? _____

_____

Seat Belt Properly Used: Yes No N/A

Opinion of Supervisor: Preventable Non-Preventable

Witness of Accident Address
_____ _____

_____ _____

Injured Employee Signature: _____

Supervisor (Please Print): _____

Supervisor Signature: _____

Supervisor Phone Number: _____

Date Completed: _____