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: ____