EMPLOYEE ACCIDENT/INCIDENT REPORT

Date & Time _____ ☐ AM ☐ PM	Location _____
Name: _____ Home Phone: _____ Office Phone: _____	Briefly describe accident: _____
Supervisor's & Department Head's Name _____	Were You Injured? ☐ YES ☐ NO Briefly describe injury: _____
Received medical treatment? ☐ YES ☐ NO	Dr. Name: _____ Address: _____

Witness Name & Phone #	Address	Statement Attached
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UNSAFE CONDITIONS: Was there an unsafe condition? If so, why did the unsafe condition exist?

UNSAFE ACTS: What did anyone do or fail to do that led to this accident/incident? Indicate specific reasons.

RECOMMENDATIONS: What action has been or should be taken to prevent a similar accident/incident from occurring?

Supervisor Signature	Date _____
Supervisor's Recommendations Approved: ☐ YES ☐ NO	
Additional Recommendations or Actions: _____	
Department Head Signature	Date _____

This form is to be used to report all accidents/incidents involving employees, regardless of where the event occurs. In addition, please forward a copy of the police report and any witness statements to the Office of Environmental Health, Safety & Risk Management within three business days of the accident or incident.