



EMPLOYEE ACCIDENT/INCIDENT REPORT

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