NORTH HEALTH DISTRICT 2
EMPLOYEE INCIDENT REPORT

NAME OF EMPLOYEE_____ DATE_____

JOB TITLE_____ SOCIAL SECURITY #_____

POSITION #_____ EMPLOYEE ID #_____

WORK LOCATION_____ WORK PHONE #_____

DATE OF INCIDENT_____ TIME OF INCIDENT_____

DATE INCIDENT REPORTED BY EMPLOYEE_____

DESCRIPTION OF INCIDENT (HOW, WHERE, WHY)_____

_____

_____

_____

TYPE OF INJURY, ILLNESS OR EXPOSURE TO OCCUPATIONAL DISEASE (CUT, BURN, ETC.)_____

_____

_____

PLACE OF OCCURRENCE (PROVIDE ADDRESS IF POSSIBLE)_____

_____

WITNESS/ES (NAMES/S AND TELEPHONE #/S)_____

_____

WAS FIRST AID ADMINISTERED AT TIME OF INCIDENT? YES____ NO___ WHAT TYPE?_____

_____

WAS MEDICAL ATTENTION GIVEN, IF SO NAME, ADDRESS AND TELEPHONE # OF ATTENDING PHYSICIAN

_____

(NOTE: If seen in ER or by private MD, send a copy of the diagnosis to Human Resources.)

SUPERVISOR'S NAME_____TELEPHONE #_____

SIGNATURE OF PERSON COMPLETING REPORT_____
TITLE OF PERSON COMPLETING REPORT_____

TELEPHONE #_____DATE REPORT COMPLETED_____

THIS FORM *DOES NOT* REPLACE THE WC-1, EMPLOYER'S FIRST REPORT OF INJURY.
(THE WC-1 WILL BE COMPLETED BY HUMAN RESOURCES).
PLEASE FAX ATTACHMENT I TO HUMAN RESOURCES @ 770-535-5899
IF THIS IS AN OCCUPATIONAL EXPOSURE, COMPLETE THE OCCUPATIONAL EXPOSURE REPORT (ATTACHMENT II) AND SEND BOTH ATTACHMENTS TO BEVERLY ROBERTSON.