

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.