DISTRICT 2 PUBLIC HEALTH
EMPLOYEE INCIDENT REPORT FORM

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 OCCURANCE (ADDRESS IF POSSIBLE) _________________________________________________________

WITNESS/ES (NAME/S AND TELEPHONE) ______________________________________________________________
_______________________________________________________________________________________________

WAS FIRST AID ADMINISTERED AT THE TIME OF INCIDENT? NO_____ YES____ WHAT TYPE?____________________
________________________________________________________________________________________________

WAS MEDICAL ATTENTION GIVEN, IF SO NAME, ADDRESS, AND TELEPHONE OF ATTENDING PHYSICIAN____________
________________________________________________________________________________________________

*IF SEEN IN ER OR BY PRIVATE MD, SEND A COPY OF THE DIAGNOSIS TO HR

SUPERVISORS NAME____________________________________ TELEPHONE#_________________________________

SIGNATURE OF PERSON COMPLETING REPORT_______________________________ DATE_______________________

TITLE OF PERSON COMPLETING REPORT________________________________________________________________

TELEPHONE # OF PERSON COMPLETING REPORT_________________________________________________________

PLEASE FAX THIS FORM TO HUMAN RESOURCES @ 770-535-5899

DISTRICT 2 PH
REV. 5/2018