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