Workers' Compensation
District 2 Public Health
Incident Notice Only

Instructions: For occupational injuries **requiring medical attention or lost work days**, call the **Telephonic Reporting Center at 1-877-656-RISK (7475)** as soon as possible within 24 hours of knowledge of injury. Complete this form for the agency's record for all other injuries.

Date incident reported by employee ___________________

Name of injured employee__________________________Office phone # _______________________

Job Title: ____

Social Security # ______________________________

Date of incident______________ Time of incident _______________

Description of incident (how, where, why?) ____

____

____

____

Type of injury (cut, scrape, burn, etc.) ____

Place of occurrence (provide address if possible)____

Witness/es (Name/s and telephone #) ____

Was First Aid administered at time of incident? Yes,__No______What type? ___________________

Supervisor's name_______________________________Telephone # __________________________

Person completing report_________________________Telephone # ____________________________

Date Report completed ____________

This form does not replace the WC-1, Employer's First Report of Injury.
FOR INTERNAL USE -
PERSONNEL RECORDS ONLY