Incident Report Form

Facility Name: _____ **Date:** _____

Location: _____ **Time:** _____

Details of the Incident:

Date of incident: _____ Time of incident: _____ (am/pm)

Describe the incident:

_____

_____

_____

_____

What exactly happened?

_____

_____

_____

How did it happen?

_____

_____

_____

Specific area where the incident occurred: _____

Condition of area where it occurred: _____

Employee(s) involved: _____

_____

Item(s) or equipment involved: _____

Witness Information:

Name: _____ Date and time of visit: _____
Address: _____
City: _____ State: _____ Zip code: _____
Phone number: _____ Email: _____

How was witness involved in the incident?

_____

_____

Please describe what you witnessed:

_____

_____

_____

Name: _____ Date and time of visit: _____

Address: _____

City: _____ State: _____ Zip code:_____

Phone number: _____ Email: _____

How was witness involved in the incident?

_____

_____

Please describe what you witnessed:

_____

_____

_____

Injury/Accident Details:

Name of injured: _____ Age:_____ Employee: YES/NO

Address: _____

City: _____ State: _____ Zip code:_____

Phone number: _____ Email: _____

Describe injury: _____

Treatment of Injury: (*leave blank if no treatment is needed)*

What was immediately done to treat the injured party?

_____

_____

Additional treatment *(circle all that apply)*:

First Aid Emergency Room Outpatient Clinic Went to see own doctor Hospital Stay

Did injured party have to miss work due to injury? If so, how many days/hours of work?

_____

_____

Action Steps:

What action has been taken to resolve the situation?

_____
_____
_____
_____

What action has been taken to prevent this incident from happening again in the future?

_____
_____
_____
_____

Form Completion Details:

Form completed by:

Name: _____ Position: _____ Phone: _____

Signature: _____ Date: _____

Manager on duty: _____

Manager signature: _____ Date: _____