

SAFETY INCIDENT REPORTING FORM

EMPLOYEE INFORMATION:

Employee Name: _____ Date of Report: _____

Employee ID: _____ Phone Number: _____

Job Title: _____ Department: _____

Supervisors Name: _____

INCIDENT INFORMATION:

Date of Incident: _____ Time of Incident: _____

Location of Incident: _____

Description of Incident:

Please provide a detailed account of what happened

Type of Incident:

- Slip/Trip/Fall
- Machinery/Equipment Accident
- Exposure to Hazardous Material
- Fire/Explosion
- Vehicle Accident
- Workplace Violence
- Other:



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EMPLOYEE INJURY OR ILLNESS:

Injuries/Illness Sustained:

If applicable, provide details of any injuries or illnesses sustained during the incident.

Was Medical Treatment Required: Yes No

WITNESS INFORMATION:

Witness Name:

Phone Number:

Witness Statement:

Include details of what the witness observed during the incident.

Witness Signature:

Date:

SIGNATURES:

Employee Signature:

Date:

Supervisor/Manager Signature

Date:
