

# Employee Injury and Incident Report Form

Instructions: This form must be completed by the injured employee or their supervisor as soon as possible following an incident. This form is formatted for printing and manual completion or local typing.

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## 1. Employee Information

Full Name:	<input type="text"/>	Employee ID:	<input type="text"/>
Job Title:	<input type="text"/>	Department:	<input type="text"/>
Supervisor Name:	<input type="text"/>	Phone Number:	<input type="text"/>

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## 2. Incident Details

Date of Incident:	<input type="text" value="MM/DD/YYYY"/>	Time of Incident:	<input type="text" value="HH:MM AM/PM"/>
Specific Location of Incident:	<input type="text"/>		
Date Incident Reported:	<input type="text" value="MM/DD/YYYY"/>	Reported To Whom:	<input type="text"/>

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## 3. Description of Incident and Injury

Describe how the incident occurred (What was the employee doing? What tools, equipment, or materials were involved?):

Describe the injury or illness in detail (e.g., cut, sprain, burn) and the affected body parts (e.g., left wrist, lower back):

## 4. Medical Treatment and First Aid

Was first aid administered on site? (Yes / No):	<input type="text"/>	Administered By:	<input type="text"/>
Was professional medical treatment sought? (Yes / No):	<input type="text"/>	Clinic / Hospital Name:	<input type="text"/>

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## 5. Witnesses

Witness 1 (Name and Contact Info):

Witness 2 (Name and Contact Info):

## 6. Signatures (For Print and Hand-Sign)

Employee Signature:	<input type="text" value="Sign on printed copy"/>	Date:	<input type="text"/>
Supervisor Signature:	<input type="text" value="Sign on printed copy"/>	Date:	<input type="text"/>