**Accident/Incident Report**

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| **Agency Name:**      |

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| **Employee Information** |
| Name:      | Personnel Number:      | Division:      |
| Date of Accident/Incident:      | Time of Accident/Incident:      a.m. [ ]  p.m. [ ]  | Date reported:      | Time reported:      a.m. [ ]  p.m. [ ]  |
| Reported to whom:      | Location of Accident/Incident:      | Witnessed by:      |
| Description of Accident/Incident:      |
| Injury [ ] Non-injury [ ]  | If injured, describe injuries:      |
| List any contributing factors (if applicable):      |
| Were you treated by a doctor for this injury? Yes [ ]  No [ ]   | If **yes**, list doctor’s name:       |
| Were you treated at a hospital? Yes [ ]  No [ ]   | If **yes**, which hospital:       |
| Did a doctor prescribe medication for your injury? Yes [ ]  No [ ]   |
| Did a doctor refer you to either of the following? Chiropractor [ ]  Physical therapist [ ]  No [ ]  |
| Did you return to work immediately after the Accident/Incident? Yes [ ]  No [ ]  | Date and time you returned to work:       |
| Have you missed any days of work due to this injury?Yes [ ]  No [ ]  | If **yes**, number of days missed from work:        |
| Signature:      | Date:      |
| **Witness Information (if applicable)** |
| Name:      | Division:      |
| Description of Accident/Incident:      |
| Signature:      | Date:      |
| **Supervisor/Manager****Complete this form within two days of incident** |
| Name:      | Was employee engaged in the regular course of employment? Yes [ ]  No [ ]  |
| Description of Accident/Incident:      |
| First Aid administered? Yes [ ]  No [ ]  |
| What could have been done to prevent the Accident/Incident?      |
| What action have you taken to prevent a recurrence or similar Accident/Incident?      |
| Signature:      | Date:      |

**Complete this form, sign and file in your agency accident report file.**