



# EMPLOYEE INCIDENT REPORT

**EMPLOYEE:** Please provide the information requested.

Name:

Telephone Number:

\_\_\_\_\_

*First Name*

\_\_\_\_\_

*Last Name*

Address:

Date of Birth:

Marital Status:

Gender:

\_\_\_\_\_

Job Title:

\_\_\_\_\_

Date of Incident:

\_\_\_\_\_

Date Reported:

\_\_\_\_\_

Name of Witness:

\_\_\_\_\_

What type of injury did you incur?

\_\_\_\_\_

What part(s) of your body were injured?

\_\_\_\_\_

*Example: cut, bruise, bite, etc.*

Describe, fully, how the incident/injury occurred:

\_\_\_\_\_

Was Nurse called?

Yes    No

\_\_\_\_\_

Time:

\_\_\_\_\_

Date:

\_\_\_\_\_

Treatment Required:

\_\_\_\_\_

Authorization for Treatment given?

Yes    No    Refused

\_\_\_\_\_

Program Supervisor Notified:

Yes    No    Date: \_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_  
[mm/dd/yyyy]

## SUPERVISOR SIGNATURE

Signature: \_\_\_\_\_

Date: \_\_\_\_\_  
[mm/dd/yyyy]