Incident Report

This form is to be filled out for all incidents/accidents/illnesses that in result in personal injury which may or may not require medical treatment. This form is to be completed by the employee with their supervisor.

Incident Date: Time: Location:

Name of person involved:

1. Description of incident:

2. Extent of injury or body part injured:

3. Treating Physician/Medical Facility of needed:

   Name of Supervisor who accompanied employee:

4. Witness to the incident:

5. How could incident/accident have been prevented:

Employee Signature: Date:

Supervisor Signature: Date:

If you feel medical treatment is not necessary, please complete the Waiver of Medical Treatment section below. Signing the waiver relates to the need for treatment now, it does not prevent any additional treatment later, if necessary.

Waiver of Medical Treatment

After completing this report, I declare that medical treatment is not necessary and I elect not to receive treatment at this time.

Employee Signature Date: