

# INCIDENT REPORT FORM

Use this form to report workplace accidents, injuries, medical situations, traffic incidents, or student behavior incidents. If possible, a report should be completed within 24 hours of the event.

Date of Report: \_\_\_\_\_, 20\_\_\_\_

## PERSON INVOLVED

Full Name: \_\_\_\_\_ Address: \_\_\_\_\_

Identification:  Driver's License No. \_\_\_\_\_  Passport No. \_\_\_\_\_

Other: \_\_\_\_\_

Phone: (\_\_\_\_) \_\_\_\_ - \_\_\_\_ E-Mail: \_\_\_\_\_

## THE INCIDENT

Date of Incident: \_\_\_\_\_, 20\_\_\_\_ Time: \_\_\_\_:\_\_\_\_  AM  PM

Location: \_\_\_\_\_

Describe the Incident: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

## INJURIES

Was anyone injured?  Yes  No

If yes, describe the injuries: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

## WITNESSES

Were there witnesses to the incident?  Yes  No

If yes, enter the witnesses' names and contact info: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_



POLICE / MEDICAL SERVICES

Police Notified?  Yes  No If yes, was a report filed?  Yes  No

Was medical treatment provided?  Yes  No  Refused

If yes, where was medical treatment provided?  On site  Hospital  Other: \_\_\_\_\_

PERSON FILING REPORT

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

Print Name: \_\_\_\_\_

OFFICE USE ONLY

Report received by: \_\_\_\_\_ Date: \_\_\_\_\_, 20\_\_\_\_

Follow-up action taken: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_