UA LITTLE ROCK | DEPARTMENT OF HUMAN RESOURCES

Injury Incident Report - Workers' Compensation

(No Medical Treatment Required)

Name:		**Age:**	**T#:**
Address:			
City:		**State:**	**Zip:**
Home Phone:		**Cell Phone:**	
Job Title:		**Department:**	
Date of Accident:		**Time of Accident:** am ☐ pm ☐	
Location of Accident:			
Description of Incident:			
Body Parts Injured:			
Personal Protective Equipment (PPE) worn?	**Yes ☐**	**No ☐**	**N/A ☐**
If yes, what type of PPE was used?			
Seat Belt Properly Used:	**Yes ☐**	**No ☐**	**N/A ☐**
Opinion of Supervisor:	**Preventable ☐**	**Non-Preventable ☐**	
Witness of Accident	**Address**		
Injured Employee Signature:			
Supervisor (Please Print):			
Supervisor Signature:			
Supervisor Phone Number:			
Date Completed:			