**WORKERS’ COMPENSATION INCIDENT REPORT**

**(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:** | | | | | | | | | | |