**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:**  |