Incident Report Form

To be completed by the employee or customer/visitor/resident/vendor immediately following any incident that resulted in injury or property damage, and turned into the supervisor. The supervisor should conduct their own investigation and turn in all necessary reporting forms to the insurance agent or carrier.

Employee Involved (Complete both boxes)
Name:
Job title:
Date of Birth:
Phone: ( )

Customer/Visitor/Employee/resident/vendor Involved
Name:
Address:
City, ST Zip:
Phone: ( )

The following sections should be completed for all incidents:	
Date of incident:	Approximate time of incident: AM / PM
Location of incident (be specific as to where, in what room or part of the property, etc):	
What happened, what was the cause of injury:	
What is the nature of the injury/ property damage:	
If injuries were involved, ☐ Ambulance used, ☐Will seek medical attention, or ☐ Medical attention not being sought at this time. (Checking this box does not prevent future medical attention should you change your mind or condition worsens.)	
Were their witnesses? ☐ Yes ☐ No List names & phone # if other than employee:	
Involved Party Signature:	Date:

Employer/Management Use only	
Received By (PRINT):	Date:
Signature:	Manager Phone: