Workers' Compensation
Incident Report for Reporting Purposes Only

WC Incident for Reporting Purposes Only Form

Instructions: Complete this form for the Agency's record for injuries, illnesses and exposures to occupational disease which **DO NOT** require medical attention or lost work time. For work-related injuries, illnesses and exposures to occupational disease requiring medical attention or lost work time, call the telephonic reporting system at **1-877-656- RISK (7475)** within 24 hours or as soon as practical after the injury, illness or exposure.

Date of Incident: _____ Time of Incident: _____

Employee's Name: _____ Employee ID: _____

Position Title: _____ Position Number: _____

Work Location: _____ Work Phone: _____

City: _____ State: _____ Zip: _____ Phone: _____

Date Incident Reported by Employee: _____

Describe fully how the accident occurred (how, when, why?): _____

_____

_____

_____

Describe the type of injury. Illness or exposure to occupational disease (cut, burn, etc): _____

_____

_____

Place of occurrence: (loading dock, bathroom - provide address if possible): _____

_____

Name(s) of Witness(es): _____ Phone: _____

Name(s) of Witness(es): _____ Phone: _____

Was First Aid administered at the time of incident? ☐ Yes ☐ No What Type?_____

To whom did you report the injury? _____

Do you required medical attention? ☐ Yes ☐ No

Name of Supervisor: _____ Phone: _____

Signature of Employee: _____ Date: _____

Person completing report: _____ Phone: _____

Title of person completing report: _____ Date report completed: _____