ACCIDENT/INCIDENT REPORT FORM

Date of Incident: _____ Time: _____ AM / PM

Weather Conditions: _____

Name of Injured Person(s): _____

Address: _____

Phone Number: _____

Description of Injury: _____

_____

Details of Incident: _____

_____

Were There Any Witness(es): Yes_____ No _____

Name of Witness(es): _____

Address of Witness(es): _____

Phone Number(s): _____

Was a Witness Statement Obtained: Yes_____ No _____

Was First Aid Administered: Yes_____ No _____

If Yes, Describe Actions Taken: _____

Did Injury Require EMS/Hospital Visit: Yes_____ No _____

Name of Hospital: _____

Employee Investigating Scene: _____

Any Photographs Taken Yes_____ No _____

Signature of Injured Party

X: _____ Date: _____

***No medical attention was desired and/or required**

X: _____ Date: _____

Signature of injured party if medical attention declined

Name of Person Filling Out Report: _____

Signature

X: _____ Date: _____