

SCIBAL ASSOCIATES

INCIDENT REPORT

Part One – To Be Completed by Employee

1. Agency Name: _____
2. Employee Name: _____
SS #: _____ DOB: _____
3. Address: _____
City: _____ County: _____ State: _____ Zip: _____
Home Phone: _____ Date of Hire: _____
4. Date of Accident of Injury: _____ Time: _____
5. Location of Incident (be specific): _____
6. Describe the injury or illness and what you were doing when it happened (use a second page if necessary): _____

7. Witnesses (and their location at the time of the incident): _____

8. When did you first report this incident? Date: _____ Time: _____
9. Did you finish work the day of the incident? Yes No
10. What part(s) of the body was/were affected (left hand, neck, etc. – be specific)? _____

11. Will you be seeking medical consultation or treatment for this injury? Yes No
12. Describe any medical treatment you have received or will receive: _____

13. If you are planning to/or have already received medical treatment, please indicate the name and address of the individual rendering the treatment: _____

I certify that this information is true and correct to the best of my knowledge and belief.

Employee Signature: _____ Date: _____

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INCIDENT REPORT

Part Two – To Be Completed by Employer

1. Name: _____ Department: _____
2. Employee Name: _____ Incident Date: _____
3. When did you first learn of any claimed injury/illness or accident?
Date: _____ Time: _____
4. Who reported it to you? _____
5. When did you first speak with the employee about it?
Date: _____ Time: _____
6. Describe in detail what the employee reported to you (be as specific as possible – use a separate page if necessary):

7. What areas of the body did the employee complain of (left hand, neck, etc.)? _____

8. Identify any potential witnesses: _____
9. What was their location at the time of the claim occurrence? _____

10. Did you speak with the witnesses? (If so, identify each and when you spoke with them):

11. Did the employee complete his/her shift or day? Yes No
12. Did the employee request/receive any medical treatment? (Explain): _____

I certify that this information is true to the best of my knowledge and belief.

Date: _____ Supervisor's Signature: _____

Printed Name: _____

Date: _____ Dept. Director's Signature: _____

Printed Name: _____