INCIDENT REPORT FORM

NAME OF EMPLOYEE_______________________________________ TIME EMPLOYEE STARTED WORK ____________________

EMPLOYEE JOB TITLE _____________________________________ DEPARTMENT/DIVISION______________________________

DATE OF INCIDENT____ TIME OF INCIDENT ____________________________________

Check box that applies to incident being reported:

❑ THREAT	❑ UNSAFE ACTS/WORK PROCESSES
❑ BOMB THREAT	❑ HAZARDOUS WORKPLACE CONDITION
❑ ROBBERY	❑ ASSUALT OR VIOLENT ACT
❑ VEHICLE ACCIDENT	❑ FIRE OR EXPLOSION
❑ WORKPLACE ACCIDENT	❑ OTHER ________________________________

DESCRIPTION (Attach a separate sheet if necessary & provide as much detail as possible. Attach photos or other records.)

WHO WAS INVOLVED (If individuals names are unknown include description, gender, structure, and other notable features)

WHERE *(Include site layout on back)* ____

WHY ____

HOW ____

WHAT DID YOU DO?

WERE THE POLICE CALLED? ☐ Yes ☐ No WHAT WERE THEIR INSTRUCTIONS/COMMENTS:____________________________

NUMBER OF PERSONS AFFECTED ____________________ THIRD PARTY OR NON-EMPLOYEE INVOLVEMENT Yes No

WERE THERE ANY WITNESSES? Yes (If so, have them complete an incident forma as well) No

NAME(S) & PHONE NUMBER(S) OF WITNESSES THAT SAW THE INCIDENT

EMPLOYEE SIGNATURE ____ DATE SIGNED____________________________

SUBMITTED TO ____ DATE _________________________

ACTION TAKEN ____

____

WAS LEGAL COUNSEL ADVISED OF THE INCIDENT? ____

(Attach a Separate Sheet if necessary)