

## Employee Incident Report

This form must be completed, reviewed with a supervisor and submitted to WCC within 24 hours.

Employee Name (last, first, middle) \_\_\_\_\_ EE#SS# \_\_\_\_\_

Department \_\_\_\_\_ Job title \_\_\_\_\_ Hire Date \_\_\_\_\_

Supervisor \_\_\_\_\_ Shift 1 2 3 other

Date of Incident \_\_\_\_\_ Time (am/pm) \_\_\_\_\_

Day Occurred S M T W TH F S

Location of Incident \_\_\_\_\_ Who was Notified? \_\_\_\_\_

Describe incident (describe what happened, how the incident occurred, include details pertaining to equipment, environment, tasks etc.)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Indicate on the Diagram the location of injury

Body Part Injured \_\_\_\_\_

Injury is a: New or Re-injury

Was first aid administered? Yes No

If yes, where? \_\_\_\_\_

What was the cause of this incident? \_\_\_\_\_

How could this incident have been prevented? \_\_\_\_\_

Did anyone witness the incident? Yes No

(Names) \_\_\_\_\_

Do you have other employment? Yes No