**Accident/Incident Report**

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| **Agency Name:** |

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| **Employee Information** | | | | | | |
| Name: | | Personnel Number: | | | | Division: |
| Date of Accident/Incident: | Time of Accident/Incident:        a.m.  p.m. | | Date reported: | | | Time reported:        a.m.  p.m. |
| Reported to whom: | Location of Accident/Incident: | | Witnessed by: | | | |
| Description of Accident/Incident: | | | | | | |
| Injury  Non-injury | | | If injured, describe injuries: | | | |
| List any contributing factors (if applicable): | | | | | | |
| Were you treated by a doctor for this injury? Yes  No | | | | If **yes**, list doctor’s name: | | |
| Were you treated at a hospital? Yes  No | | | | If **yes**, which hospital: | | |
| Did a doctor prescribe medication for your injury? Yes  No | | | | | | |
| Did a doctor refer you to either of the following? Chiropractor  Physical therapist  No | | | | | | |
| Did you return to work immediately after the Accident/Incident? Yes  No | | | | Date and time you returned to work: | | |
| Have you missed any days of work due to this injury?  Yes  No | | | | If **yes**, number of days missed from work: | | |
| Signature: | | | | | Date: | |
| **Witness Information (if applicable)** | | | | | | |
| Name: | | | | | Division: | |
| Description of Accident/Incident: | | | | | | |
| Signature: | | | | | Date: | |
| **Supervisor/Manager**  **Complete this form within two days of incident** | | | | | | |
| Name: | | | | | Was employee engaged in the regular course of employment? Yes  No | |
| Description of Accident/Incident: | | | | | | |
| First Aid administered? Yes  No | | | | | | |
| What could have been done to prevent the Accident/Incident? | | | | | | |
| What action have you taken to prevent a recurrence or similar Accident/Incident? | | | | | | |
| Signature: | | | | | Date: | |

**Complete this form, sign and file in your agency accident report file.**