Company Logo

Workplace Incident Report Form

Information About the Employee or Person Involved in the Incident:

Name: ____

Job Title: ____

Department: ____

Incident Details: Location of Incident: ____

Date and Time of Incident: ____

Nature of Incident: (Please check all that apply) ☐ Slip, Trip, or Fall ☐ Machinery or Equipment Accident ☐ Fire or Explosion ☐ Chemical Spill or Exposure ☐ Workplace Violence ☐ Injury or Illness ☐ Property Damage ☐ Near Miss ☐ Other (Please specify): ____

Description of Incident: (Provide details about what happened, how it happened, and factors leading to the event, such as environmental conditions. Be as specific as possible and use extra sheets if necessary.)

Witness Information:

Name: ____

Contact Number: ____

Email: ____

Immediate Action Taken: ☐ First Aid Provided ☐ Medical Assistance Requested ☐ Emergency Services Notified (Specify service): _____________________ ☐ Evacuation Performed ☐ Hazardous Area Secured ☐ Incident Scene Preserved ☐ Other (Please specify): ____

Supervisor's Remarks:

Additional Information (if applicable):

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Attachments: ☐ Photos ☐ Video ☐ Sketch Diagram ☐ Other (Please specify):
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Recommendations for Preventing Future Incidents:

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Signature of Reporter: ______________________________________ Date Report Completed: ___________

Name & Job Title of Reporter: ____

Please submit this form to your immediate supervisor and HR within 24 hours of the incident.

Note: This form is confidential and for internal use only.