PEOPLE'S PLACE
EMPLOYEE INCIDENT/INJURY REPORT FORM

NAME OF EMPLOYEE _____

ADDRESS (INCLUDE COUNTY) _____

TELEPHONE NUMBER OF EMPLOYEE: _____ PROGRAM: _____

HOURS WORKED PER WEEK: _____ NORMAL STARTING TIME: _____ POSITION: _____

DATE AND TIME OF INCIDENT: _____ DATE AND TIME RETURNED TO WORK: _____

NATURE OF INJURY AND PART(S) OF BODY AFFECTED (E.G., SPRAINED MIDDLE FINGER OF LEFT HAND): _____

WERE ANY EMERGENCY SERVICES NECESSARY? (E.G. 911, AMBULANCE, PARAMEDICS, MOBILE CRISIS) _____

WAS MEDICAL CARE PROVIDED? _____ IF YES, GIVE NAME AND ADDRESS OF PHYSICIAN OR HOSPITAL (ATTACH COPY OF PAPERWORK FROM PHYSICIAN OR HOSPITAL): _____

IF NO, STATE WHY. _____

WHERE DID THE ACCIDENT OCCUR? _____

WHAT WAS THE EMPLOYEE DOING WHEN THE ACCIDENT OCCURRED? (USE REVERSE SIDE IF ADDITIONAL SPACE IS NEEDED)

WHAT DO YOU RECOMMEND TO PREVENT A REOCCURRENCE OF THIS ACCIDENT AND ACCIDENTS DUE TO SAME CAUSE OR CAUSES?

LIST THE NAMES OF ANY WITNESSES TO THE ACCIDENT: _____

DATE SUPERVISOR WAS NOTIFIED? _____ TIME SUPERVISOR NOTIFIED? _____

SIGNATURE OF REPORTING STAFF	DATE	SIGNATURE OF SUPERVISOR	DATE

SUPERVISOR COMMENTS: _____

Revised 2/2015