



ACCIDENT/INCIDENT REPORT

Name of Employee: _____

Age: _____ Sex: _____ Years of Service: _____ Time at Present Job: _____

Job Title _____ Dept/Project: _____ Supervisor: _____

Date of Incident/Accident _____ Time: _____ Date Reported: _____

Describe Incident/Accident: _____

Witnesses _____

Injuries: First Aid only? Yes No; Sent to Occupational Health? Yes No

Unsafe Act? Yes No. If yes, explain: _____

Based on the information, what actions have been taken to prevent reoccurrence? _____

Investigated by: _____ Title/Dept _____ Date: _____

Project Mgr Review: _____ Date: _____ VP's Review: _____ Date _____

Safety Committee Review _____ Date: _____