Incident Report Form

(for No Lost Time/No Medical Cost *ONLY*)

Last Name:	First Name:	Sex: ☐ F ☐ M	Date of Birth: (MM/DD/YY)

Department:	Supervisor's Name:

☐ **I do not choose to complete an on-the-job injury package for this incident because I do not anticipate seeing a physician or losing time from the workplace.**

Briefly describe what happened:

Date of Incident: (MM/DD/YY)	Time of Incident: ☐ a.m. ☐ p.m.	Part of Body Involved:
		Type of Injury:

Location of Incident (Building):	Witnesses:

Cause of Incident:	Was a safety rule violated? ☐ Yes ☐ No	Date Reported (MM/DD/YY)
	Employee Hire Date:	

Signature Person Involved:	**Date completed:**
Signature Supervisor/Foreman:	**Date completed:**

Supervisor's Actions:

Safety Coordinator Comments:

Department Phone Number:	Point of Contact:

No matter how slight the injury, it should be reported on this form.
Please send this form to Operations Division Safety Office within one workday.