# ACCIDENT, INJURY OR ILLNESS REPORT

Today's Date: ____________________ Incident Report ID: __________ -- __________
MMDDYY Employee Last Name

## EMPLOYEE INFORMATION

Employee Name: ____________________ Supervisor: ____________________

Date of Incident: ____________________ Length of Employment: ____________________

Project Name: ____________________

## INCIDENT DESCRIPTION

Where Onsite: ____________________

Time of Day: ____________________

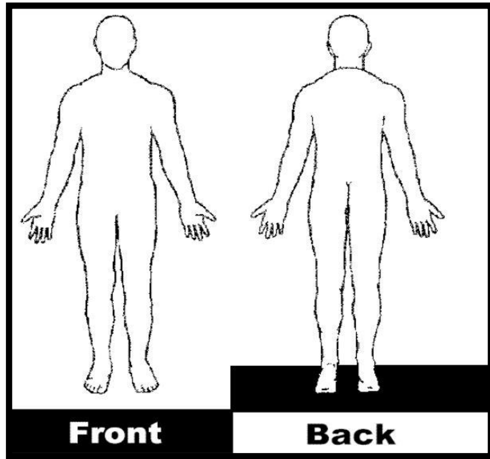
How Did it Occur: ____________________

Other Details: ____________________

Did Employee Return to Work: ____________________

## TREATMENT REQUIRED

Place an X on location of injury:




No treatment required (No drug screen required.)

**Indicate treatment for injury/illness:**

First Aid Administered by Safety Manager

Minor Injury/Non-Emergency Medical Treatment

Hospitalization (less than 24 hours)

Hospitalization (longer than 24 hours)

Other: ____________________

**For any of the above, confirm drug screen ordered:**

## REPORT PREPARER INFORMATION

Report Prepared By:

Signed: ____________________ Date: ____________________

Name: ____________________ Time: ____________________

Title: ____________________ Phone: ____________________