Employee Incident Report

This form must be completed, reviewed with a supervisor and submitted to WCC within 24 hours.

Employee Name ______________________________ EE# SS# ______________
Last First MI

Department ______________ Job title ______________ Hire Date ______________

Supervisor ______________________ Shift ☐ 1 ☐ 2 ☐ 3 ☐ other

Date of Incident ______________________ Time (am/pm) ______________________

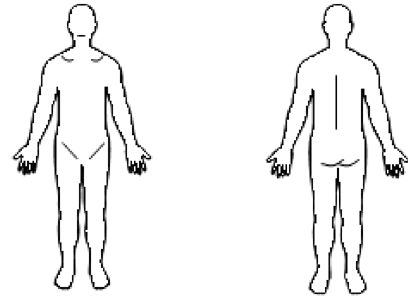
Day Occurred ☐ S ☐ M ☐ T ☐ W ☐ H ☐ F ☐ S

Location of Incident ______________________ Who was Notified? ______________________

DESCRIBE INCIDENT

(describe what happened, how the incident occurred, include details pertaining to equipment, environment, tasks etc.)

Indicate on the diagram the location of injury



Body Part Injured ______________________________

Injury is: ☐ New ☐ Re-injury

Was first aid administered? ☐ Yes ☐ No

If yes, where? ______________________________

What was the cause of this incident? ______________________________

How could this incident have been prevented? ______________________________

Did anyone witness the incident? ☐ Yes ☐ No

(Names) ______________________________

Do you have other employment? ☐ Yes ☐ No

If yes, where? ______________________________

______________________________ ______________
Employee Signature Date

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