Workplace Medical Incident Form

Employee Details

Name:

Employee ID:

Department:

Position:

Incident Details

Date of Incident:

Time of Incident:

Location:

Incident Description:

Injury/Illness Details

Type of Injury/Illness:

Medical Attention Required: Yes No

Medical Provider (if applicable):

Witnesses

Witness(es):

Reporter

Reporter Name:

Signature:

Report Date:

Submit