NORTHERN HILLS TRAINING CENTER

WORKMANS' COMPENSATION INCIDENT REPORT FORM

EMPLOYEE NAME: _____

EMPLOYEE PHONE: _____

DATE OF INCIDENT: _____ **TIME OF INCIDENT:** _____

PROGRAM AREA: _____

WHERE DID THE INCIDENT OCCUR? _____ **Was there an Injury (Please Circle)? Yes No**

WAS THERE A WITNESS? (Please Circle) YES NO WITNESS NAME: _____

WAS THERE EQUIPMENT, MACHINERY, ADAPTIVE EQUIPMENT, OR MEDICAL EQUIPMENT INVOLVED IN THE INCIDENT? (Please circle) YES NO N/A

IF EQUIPMENT WAS USED WERE PROPER SAFETY PROCEDURES FOLLOWED? (Please Circle) YES NO N/A

WAS THERE ENVIRONMENTAL HAZZARDS RELATED TO THE INCIDENT: (Please Explain) _____

_____

WHAT TASK/WORK RESPONSIBILITY WERE YOU PERFORMING WHEN THE INCIDENT OCCURRED? _____

_____

PLEASE FULLY DESCRIBE THE INCIDENT: _____

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IF MORE SPACE IS NEEDED, PLEASE CONTINUE ON THE OTHER SIDE OF THIS FORM.

DO YOU WISH TO SEE A DOCTOR AT THIS TIME? (Please circle) YES NO

I AGREE THAT THE ABOVE REPORT IS TRUE AND ACCURATE.

EMPLOYEE SIGNATURE: _____ **DATE:** _____