Brickstreet INSURANCE

Incident Report

To be completed by injured worker immediately following incident

WHEN

Date of incident:	Time of incident:
Was incident reported immediately to supervisor? ☐ YES ☐ NO	If not, please explain:

WHO

Employee name:		Job title:
Department:	Age:	Length of employment:
Names of witnesses (attach witness statements separately, if available):		

INJURY

Describe how your injury occurred (specify the cause, what you were doing, and equipment/objects involved):	
Nature/extent of injuries (include body part injured):	
Exact location where accident occurred (collect and include photographs):	
Was first aid administered? ☐ YES ☐ NO	
Did you see a doctor about your injury? ☐ YES ☐ NO	If yes, please list the following information:
Doctor's name:	Doctor's phone number:
Date of visit:	Time of visit:

CAUSES

Direct cause of injury (event that directly caused injury):	Was a third party involved?
	Was equipment involved in (or did it cause) the injury? ☐ YES ☐ NO

SUGGESTIONS

What could have been done to prevent this injury?

SIGNATURES

Employee Signature	**Date**
Supervisor's Signature	**Date**
Witness Signature(s)	**Date**

Return this form to your supervisor.