Employee Incident Report

**** Complete at time of occurrence or immediately after shift and send to Staffing* *Call Staffing immediately to report****

Employee Full Name: _____

Employee Address: _____

Employee Phone: _____ Employee Email: _____

Date of Incident: _____ Time of Incident: _____ AM ☐ PM ☐

Name of Facility: _____

City / State Facility Located: _____

Time Work Day Began: _____ AM ☐ PM ☐ Did you finish your shift: Yes ☐ No ☐

Describe nature of incident: (circle all that apply)

Lifting / Repositioning Bending Resident to Staff Slip / Trip / Fall Laceration / Bruising
Twisting Squatting Staff to Staff Bruise / Confusion Burns
Other _____

Where did you get treatment: (circle all that apply)

Hospital Emergency Room Family Doctor Chiropractor No Treatment
Dr.'s Name: _____ Address: _____

What were you doing just before the incident occurred: Describe the activity as well as any equipment, tools or supplies you were using. Be specific.

_____
_____
_____

Where were you when the injury occurred: _____
_____
_____

Describe what happened / Who Involved / Witnesses: Tell us how the injury occurred. Be specific. (your activity, objects involved, **witnesses,** how injury occurred, etc.) If you need more space, please use the back of this form.

_____
_____
_____
_____
_____
_____

_____ _____

Signature of person making this report Date

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800-727-1912
Staffing Fax: 712-277-4547
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