



Incident Report

To be completed by staff within 12 hours of incident/accident

Incident Date: _____ Incident Time: _____

Injured Persons Name: _____

Address: _____

Phone Numbers: _____

Gender: _____ Date of Birth: _____

Details of Incident: _____

Does injury require hospital/physician? Yes _____ No _____

Hospital/Physician Name: _____

Address: _____

Phone Number: _____

Injured Person/Representative Signature: _____ Date: _____

Additional Notes/Instructions: [include list of witness statements] _____

Prepared By: _____

Signature: _____ Date: _____