INCIDENT REPORT

This report should be completed whenever an incident occurs which could have potentially resulted in injury or property damage. Use the reverse side if additional space is needed.

Name of person making the report: ______________________________
LAST FIRST MI

Department: ______________________ Phone ______________

Describe the incident you are reporting: ______________________

When did you observe the incident or condition?
Date: _____ / _____ / _____ Time: ____________ A.M. / P.M.

Where did the incident or condition occur? (be specific) : ______________

What action did you or anyone else take upon observing the incident or condition? _____

Signature: ______________________ Date: ____________

THIS SECTION TO BE COMPLETED BY DEPARTMENT HEAD

Report received by: ______________________
Date: ______________ Time: ____________ A.M. / P.M.
Action, if any, taken: ______________________

Follow-up action planned: ______________________

Disposition: ______________________

Signature: ______________________ Date ____________

Received by Div. of Safety on: ______________
Reviewed by Safety and Accident Review Committee on: ______________

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