Workplace Incident Report Form

Safety & Compliance | US

COMPANY / SITE	REPORT #	DATE OF REPORT	REPORTED BY
		____ / ____ / _____	

INCIDENT DETAILS

☐ Date of incident

Time of incident _____

Exact location _____

Incident type ☐ Injury ☐ Near miss ☐ Property damage ☐ Environmental ☐ Security ☐ Other

OSHA recordable? ☐ Yes ☐ No ☐ To be determined

Description of what happened

INJURED / AFFECTED EMPLOYEE

Employee name _____

Job title _____

Department _____

Date of hire _____

Nature of injury / illness _____

Body part(s) affected _____

First aid given on site ☐ Yes ☐ No ☐ N/A

Medical treatment ☐ None needed ☐ Doctor / urgent care ☐ ER / hospital ☐ 911 called

WITNESSES

Witness 1 — name and contact _____

Witness 2 — name and contact _____

Witness statements attached ☐ Yes ☐ No ☐ N/A

IMMEDIATE ACTIONS TAKEN

	YES	NO	N/A
Area secured / hazard isolated	○	○	○
Equipment locked out / tagged out	○	○	○

Scene photos taken ☐ Yes ☐ No

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Other immediate actions

ROOT CAUSE & PREVENTION

Contributing factors

Root cause

Corrective actions to prevent recurrence

Responsible person / deadline

SIGN-OFF & OSHA REPORTING

OSHA 300 Log updated ☐ Yes ☐ No — not recordable ☐ Pending determination

Workers' comp claim filed ☐ Yes ☐ No ☐ Pending

Supervisor signature

Safety manager signature

Date closed

Notes

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