RMD Management – INCIDENT/ACCIDENT REPORT

Date of Report: _____ Company (circle one):

Name of Injured Individual: _____ Job Title: _____

Phone# of Injured Individual: _____ DOB: _____ SS#: _____

Address of Injured Individual: _____

Name of Individual Completing this Report: _____

Supervisor's Name: _____ Location of Incident: _____

Date of Incident: _____ Time of Incident: _____

Task Being Performed: _____

Names of Witnesses: _____

Describe How the Incident Occurred: _____

_____

Describe All Injuries and/or Damages (*people, equipment, vehicles*): _____

_____

Was First-Aid Given? Explain: _____

Was Medical Care Required? Explain in Detail *(Was medication prescribed? Were stitches required? Et cetera)*

_____

_____

What Training Was Given to Avoid This Type of Incident in the Future? _____

_____

Disciplinary Action Taken (if necessary): _____

_____

WCF Claim Filed? WCF Claim # if Filed: _____ Date Filed: _____

OSHA 300 Reportable Recordable

List any Job Restrictions or Days Away from Work: _____

_____

Was Employee Drug Tested: If Tested Location & Date of Drug Test: _____

Please print name if signature is not legible.

Employee Signature: _____ Date: _____

Supervisor Signature: _____ Date: _____

Manager Signature: _____ Date: _____