Department of Human Resources – Office of Risk Management

INCIDENT REPORT

Please complete if not filing a workers' comp claim or not seeking treatment by a doctor

Please Print

Name (**Person who experienced the incident**) : ____________________Date of Birth: __/__/______

Address: _________________________________ Phone #: (   )__________-______________

City: ___________________ State:____________ Zip:_________________

District extension:_________ **Date of Incident**: __/__/__ Time of Incident:________ a.m. p.m.

Title:_________________________ Department:________________________

Specific point at location where incident occurred (if not an AVC location, provide name of location & address; include room number or other description):

____

Witness(es) to the incident? Yes____ No___ if yes, name(s)_____________________________

____

Description of how incident occurred:____

____

____

____

Part of body affected (i.e. back, left wrist, right eye, etc.)?____________________________________

____

Time you began work on the day of the incident?______________ a.m. p.m.

Time you began clinical rotation on the day of the incident?___________ a.m. p.m.

What is your regular schedule? M T W TH F Hours per day: _______

Hours per week:__________ Social Security #:___________________________

Name of your immediate supervisor: ___________________________________

How could the incident have been prevented?____

Signature of person who experienced incident: __________________ Date:____/_____/____

Supervisor signature:______________________________ Date:________/_____/____

Additional comments:
Page 2.