Incident Report Form

Surname: .... First Name/s: ....

Age: ....

Day and Date of incident: ....

Time of accident: .... Time shift commenced: ....

Usual employment location/department: ....

Location of incident: ....

Who was at fault?.. Fleet vehicle involved: ....

How did the incident occur? What were the events leading up to the incident?
(Describe in detail the events that caused the incident. Attach additional information if necessary)

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Was anybody else involved in the incident? If yes please provide details.

....
....

Consequences of the Incident

Injury
- ☐ No injury
- ☐ First aid
- ☐ Medical treatment
- ☐ Lost time
  (Not available for work the day after injury)
- ☐ Fatality

Person Affected
- ☐ Employee
- ☐ Contractor
- ☐ Third party

Estimated Damage
- ☐ Vehicle: $ _________
- ☐ Other: $ _________

Witness's names and contact numbers (attach witness statements if available)

Name	Contact Details

SAMPLE

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To whom was the incident reported?--

When was the incident reported?--

In your opinion, what action if any could be taken to prevent a recurrence of the incident?

Was an ambulance called?	☐ No	☐ Yes→	Incident number: ____________
Were the police called?	☐ No	☐ Yes→	Incident number: ____________
Was trauma counseling offered?	☐ No	☐ Yes→	Date Contacted: ____________
Was medical treatment sought?	☐ No	☐ Yes→	Location: ____________
			Date & Time: ____________

---------------------------- Employee Name ---------------------------- Signature ---------------------------- Date

SUPERVISOR USE ONLY

To whom was the incident reported?

Date and time incident was reported?

Supervisor comments and notes: --

Supervisor follow-up action required: --

Target date for follow-up: --

Follow-up action to be performed by: --

Have all possible actions been taken to prevent a re-occurrence? ☐ No ☐ Yes → Explain

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---------------------------- Supervisor Name ---------------------------- Signature ---------------------------- Date

SAMPLE