Incident Report Form

Injured Worker's Last Name:	First Name:	Occupation:

Location where injury/accident occurred:	First Aid Provider:
Hospital or Clinic Attended:	Physician's Name:
Nature of Injury:	Location of Incident:
Person who transported employee:	

Will this be a lost-time injury? ❑ No ❑ Yes	Is injury work-related? ❑ No ❑ Yes
Were any subcontractors involved? ❑ No ❑ Yes	Was the MOL called?[1] ❑ No ❑ Yes

Injury Details

Date and Hour of Injury				Date and Hour Reported to Employer			
Day	Month	Year	Time	Day	Month	Year	Time
Date and Hour Last Worked				**Normal Working Hours**			
Day	Month	Year	Time	From		To	
					a.m. p.m.		a.m. p.m.

Who was the injury reported to?
What caused the injury? Describe the injury, the body part involved and specify left or right side (use back of sheet if necessary).
Describe the worker's activities at the time of the injury. Include details of equipment or materials used (use back of sheet if necessary).
Did anyone else witness the accident or know more about the injury?

[1] Reasons to call the MOL: fatality, critical injuries (defined as an injury of a serious nature that: places life in jeopardy, produces unconsciousness, results in substantial loss of blood, involves the fracture of a leg or arm, involves the amputation of a leg, arm, hand or foot, consists of burns to a major portion of the body, causes the loss of sight in an eye), fire, explosion or hazardous material release, lost-time injuries or accident requiring medical treatment, occupational illnesses, any worker who has had their fall arrested, any 'prescribed incident', or property damage >$500.

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