



Incident Report

To be completed by staff within 12 Hours of Incident/Accident

Incident Date: _____ Incident Time: _____

Injured Person Name: _____

Address: _____

Phone Number: _____

Male/ Female: _____ Date of Birth: _____

Details _____ of _____ Incident:

Who Was Injured Person? _____

Type of Injury _____

Does Injury Require Hospital/ Physician? Yes: _____ No _____

Hospital Name: _____

Address: _____

Hospital Phone Numbers: _____

Injured Person/Party Signature/ Date: _____ / _____

Important Notes and Instructions: _____

Prepared By: _____ Date: _____

Name of Approved By: _____ : Signature _____