Injury, Incident, or Concern Form

Instructions: Report all injuries, incidents, and concerns immediately and submit this form within 24 hours.

Name of Employee Reporting: _____ Date of Report: _____

Date of Occurrence: _____ / _____ / _____ Time of Occurrence: _____ : _____ □ AM □ PM

Report Type: □ Injury □ Incident □ Concern

Individual(s) Involved		
1	Name:	Phone:
	Address:	□ Employee □ Client □ Volunteer □ Other _____
2	Name:	Phone:
	Address:	□ Employee □ Client □ Volunteer □ Other _____
□ Additional Information Attached		

Injury Details
Were there any injuries? □ Yes □ No (If No, skip to the next section)
If yes, who was injured? □ Individual #1 □ Individual #2 □ Other _____
Describe the injury:
Were there any witnesses? □ Yes □ No (If Yes, obtain Witness Reports)
Was medical attention refused a the time of the injury? □ Yes □ No
If no, who provided the medical attention (hospital, medical facility, EMT, etc.)?

Description
Please describe the incident or concern in detail (Who? What? Where? When? Why? How?):
□ Additional Information Attached

Resolution (To be Completed by a Supervisor)
□ Additional Information Attached

Supervisor Signature Date Received

Director Signature Date Resolved