EMPLOYEE INCIDENT REPORT

To be completed when no "outside" medical treatment is necessary at the time of the incident.

Employee Last Name	First Name	Middle Name or Initial
Property # and Name	**Job Title**	**Property Manager/Supervisor Name**
Date of Incident	**Time of Incident**	**Location of Incident**

Describe Incident (include machine, object or substance involved. Please be specific as possible.

What, if anything, could be done to prevent a similar incident?

Employee Signature: _____

Immediate Supervisor Signature: _____

Additional Comments:

ATTENTION: If at any time, OUTSIDE medical treatment is necessary as a result of this incident, you must file a claim. See your Property Manager/Supervisor to file an accident report.