KING
Value • Care • Trust

EMPLOYEE INCIDENT REPORT

LOCATION: **PHONE #:**

******Please complete this form in your own handwriting and return it to your employer immediately. ******

EMPLOYEE INFORMATION

Employee Name:	Social Security Number:	Date of Birth:	
Street Address:	City:	State:	Zip:
Your Position:	Date of Hire:	Supervisor's Name:	

INCIDENT INFORMATION

Date of Incident:	Time of Incident:	Date Reported:	Reported to Whom?:
Type of Injury:	Did you require medical treatment?	Date of Treatment:	
Name of Physician/Clinic/Hospital Providing Medical Treatment:		Phone Number:	
What were you doing when the incident/injury occurred?:			
Describe how the incident happened:			
Where specifically did the incident occur?:			
Describe the part(s) of your body injured:			
Did anyone witness the incident?:	Please List Names of Witnesses:		
Have you ever been treated for a similar injury?:	Describe previous treatment:		
If yes, when?:			
Previous Treatment Medical Provider Name & Address:			

Signature: _____ Date: _____