INCIDENT REPORT FORM

☐ PLEASE CHECK CLASSIFICATION OF INCIDENT(S):
☐ Personal Injury    ☐ Personal Loss    ☐ Property Damage    ☐ Property Loss

DATE OF INCIDENT: ____________________ TIME OF INCIDENT: ____________ ☐ a.m. ☐ p.m.

NAME OF PERSON: ________________________________________________________________

STREET ADDRESS: ________________________________________________________________

_________________________________     ________ ____   _______________  
(City)                         (State)                         (Zip Code)  

CONTACT TELEPHONE NUMBER: ____________________________ ☐ Cell ☐ Home ☐ Work

EMPLOYER’S NAME: ________________________________________________________________

DATE RETURNED TO WORK: ____________________ NUMBER OF DAYS LOST: ____________

PLEASE DESCRIBE THE NATURE OF INJURY OR LOSS:

________________________________________________________________________________________

________________________________________________________________________________________

________________________________________________________________________________________

LIST OF WITNESSES:

<table>
<thead>
<tr>
<th>Name</th>
<th>Telephone Number</th>
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MEDICAL ATTENTION REQUIRED: ☐ Yes ☐ No

PROVIDED BY: ____________________ LOCATION: ____________________

WAS TRANSPORT REQUIRED: ☐ Yes ☐ No    METHOD: ☐ Ambulance ☐ Vehicle

DATE INSURANCE COMPANY NOTIFIED: ____________________ P.O.C.: ____________________

REPORTED BY: ____________________ DATE: ____________________

REPORTED TO: ____________________ DATE: ____________________

Revised 12.2013