Incident/Accident Report

Client Company: ___________________________Employee:________________________ Department:____________

Date of Incident: __________________Time of Incident: _____a.m./p.m.

1. **Type of Incident:** Slip/Fall Cut/Puncture Wound Chemical Spill Occupational Exposure

Vehicle Other: ____

Was medical care required? Yes No

Witness Name:____ Phone #:___________________________

Date and Time Reported: ____________________

Witness description of the Incident /Accident is:

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Witness Signature:____Date:________________