INCIDENT REPORTING FORM

Name_____ Job Title_____
First Middle Last

Date of Injury:	Hour: AM PM	Time Left Work: AM PM
Department Name:	Name of Supervisor:	Date Reported to Supervisor:
Exact Location of Accident:		Name of Witness:

Describe Accident (What was injured worker doing; what objects, machines or materials were involved):

Employee Signature_____ Date_____

Supervisor Statement:

Supervisor Signature_____ Date_____

When complete submit it ASAP to Environmental Health and Safety, Facilities 106 or estenehjem@linfield.edu