

Construction Site Workersâ€™™ Compensation Incident Report

Employee Information

Full Name

Employee ID/Number

Job Title

Contact Number

Incident Details

Date of Incident

Time of Incident

Location of Incident

Supervisor Name

Witness(es) Name(s)

Description of Incident

Cause of Incident (if known)

Injury Information

Description of Injury/Illness

Part(s) of Body Affected

Was First Aid Given?

Was Medical Treatment Sought?

If Yes, Name of Medical Provider

Additional Information

Equipment or Tools Involved

Corrective Actions Recommended

Additional Comments

Reporting

Report Completed By

Date

Signature