Janitorial Services Workersâ€™ Compensation Incident Form

Employee Information

Employee Name

Employee ID

Job Title

Department/Location

Incident Details

Date of Incident

Time of Incident

Location of Incident

Describe What Happened

Describe the Injuries

Medical Treatment

Was Medical Treatment Provided?

If Yes, Facility/Clinic Name

Witnesses

Witness Name(s)

Witness Statement(s)

Supervisor Information

Supervisor Name

Date Reported