

Public Transportation Workersâ€™™ Compensation Incident Report

Employee Information

Full Name

Employee ID

Department/Position

Phone Number

Incident Details

Date of Incident

Time of Incident

Location

Describe what happened

Witness(es)

Equipment/Vehicle involved

Injury Information

Nature of Injury

Part(s) of body affected

Severity (if known)

Medical Attention Required?

Treatment Administered / Hospital or Clinic Name

Other Details

Immediate Actions Taken

Supervisor Notified (Name)

Date/Time Supervisor Notified

Reporting Employee

Name

Signature

Date

