

Noise-Induced Hearing Loss Incident Form

Date of Incident

Time of Incident

Employee Name

Employee ID

Department/Location

Describe the Incident

Specific Source of Noise

Estimated Noise Level (dB)

Duration of Exposure

Was Hearing Protection Used?

Type of Hearing Protection

Symptoms Noticed

Actions Taken After Incident

Reported To (Supervisor/Department)

Additional Comments

