Workplace Injury Reporting Form

| Employee Name | | | |
|----------------------|-----------------|---------------|----------------|
| Employee ID | | | |
| Department | | | |
| Position | | | |
| Date of Incident | | | |
| Time of Incident | | | |
| Location of Incident | Т | ype of Injury | Description of |
| | | | |
| Incident | Witnesses (if a | ny) | Actions Taken |
| | | | |
| Reported By | | | |
| Report Date | | | |