Incident Report Form

Gordon State College

This form should be used if no injury is claimed and/or no medical treatment is needed. If medical treatment is needed, the Accident Report Form should be completed.

Date incident reported by employee_____

Name of Injured employee_____Office Phone#_____

Job Title:_____SSN_____

Date of incident_____Time of incident_____

Description of incident (how, where, why?)_____

_____

_____

Type of injury (cut, scrape, burn, etc.)_____

_____

Place injury occurred (bldg. name, room #, etc.)_____

_____

Was first aid administered? Yes_____No_____

What Type?_____

Witnesses (names and numbers)_____

_____

Supervisor's name_____Phone #_____

Person completing report_____Phone #_____

Date report completed_____