Incident Report - Ergonomic-Related Injury

Employee Name

_____

Date of Report

_____ / _____ / _____

Job Title

_____

Department

_____

Incident Details

Date of Injury

_____ / _____ / _____

Time

_____ : _____

Location

_____

Describe the Incident (include what task was being performed and ergonomics risk factors):

Describe the Injury (body part affected, symptoms):

Did employee seek medical attention?

[ ] Yes [ ] No

Witnesses

Name(s) and Contact Info:

Corrective Actions Taken

Describe any immediate actions to prevent recurrence:

Report Completed By

_____

Signature

_____

Date

_____ / _____ / _____