Workplace Injury Reporting Form

Employee Information

Employee Name

Employee ID

Department

Job Title/Position

Incident Details

Date of Incident

Time of Incident

Location

Describe the Injury and How It Happened

Type of Injury e.g., cut, burn, sprain

Body Part Affected

Was First Aid Provided? Select

If Yes, By Whom?

Witnesses (if any) Enter names

Notified Supervisor/Manager? Select

Additional Comments or Details

Employee Signature

Date