WEST BEND®
*General / OSHA*

# Incident Report

Last Name: _____ First Name: _____

Date of Incident: _____ Time: _____a.m./p.m. Location: _____

Treatment: _____ First Aid: _____Medical: _____ Where Treated? _____

Description of incident by person involved. Be specific:

_____
_____
_____

Name and address of witness(es):

_____

Description of incident by witness(es). Be specific:

_____
_____
_____

Describe nature and extent of apparent injury:

_____
_____
_____

Emergency treatment given (To be completed by person providing treatment.):

_____
_____

Was physician called or consulted? Yes_____ No_____ Time: _____ a.m./p.m.

***ATTENTION EMPLOYEE: If medical attention is sought at another time, you must notify facility that you have seen a physician.***

Specify machine, tool, substance, or object connected with the accident:

_____
_____

Unsafe mechanical/physical/environmental condition at time of accident (be specific):

_____
_____

Personal factors (e.g., attitude, lack of knowledge or skill, slow reaction, fatigue):

_____
_____

Action plan to prevent recurrence (e.g., modification of machine, mechanical guarding, environment, training, and the immediate corrective actions taken):

1. _____

2. _____

3. _____

4. _____

Actions taken on recommendations (Include date completed):
_____
_____
_____

***ASK HOW AND WHY UNTIL THE FUNDAMENTAL CAUSE IS FOUND.***

Date of report: _____ Time: _____

_____ _____
Signature of person making this report Title