

Accident Incident Statement Form

General Information

- Full Name: _____
- Employee ID (if applicable): _____
- Department: _____
- Date & Time of Incident: _____
- Location of Incident: _____

Incident Type (Check all that apply)

- Slip and Fall
- Vehicle Collision
- Equipment Malfunction
- Exposure to Hazardous Material
- Other (Specify): _____

Incident Aspect	Employee's Statement	Supervisor's Statement	Witness's Statement
Cause of Incident			
Actions Taken			
Injuries Reported			
Property Damage			
Safety Violations			
Medical Treatment Given			
Corrective Measures			

Further Investigation Needed			
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Employee's Description of the Incident

- Provide a detailed explanation:

Supervisor's Comments

- Supervisor's perspective on the incident:

Safety Recommendations

- Measures to prevent similar incidents in the future:

Acknowledgment & Signatures

I confirm that the above statement is accurate.

- Employee Signature: _____ Date: _____
- Supervisor Signature: _____ Date: _____