Appalachian State University EMPLOYEE INCIDENT REPORT

Appalachian STATE UNIVERSITY. BOONE, NORTH CAROLINA

Instructions: Employee must complete report. If more room is needed, continue in a Word document and attach it to this submission.

Employees are required to complete this form for all incidents and near hits. This form should be completed in its entirety and should be an accurate and truthful account of the accident/incident. Providing false and/or misleading information may result in disciplinary action up to or including dismissal and/or additional criminal and/or civil liability. This form should be completed by the employee only.

Supervisor Review: If an employee is unable to complete this form, the Supervisor must list reason(s) for assisting or completing this report.

My signature below certifies that the information I have provided is true and accurate. I further understand that this information may be used to determine whether the claim will be paid or denied and that I should not complete this form unless there are exceptional circumstances present preventing the employee from completing this form. Check ☐ Not applicable (employee completed form) or sign below if you assisted with the completion of this form.

Supervisor Name: Signature:

Employee Information			Date/Location Information	
Name (Full):			Date of Incident: / /	Time of Day:
Employee ID #:			Date Reported to Supervisor: / /	Time employee began work:
Job Title:		Male	Home Address:	
Telephone #:		Female		
Department:			Incident Location (address, Building name, office, cross streets, fire name, woods, facility, room #, etc.):	
Supervisor:	Phone #:			
Date Hired:	Time in Current Job:		County:	

Witness Information

Were there any witnesses to the incident? Yes No Number of Witnesses (if applicable): ________________

If yes, list all known witnesses/phone #'s below, please include additional names on attachment if needed.

Name:	Phone #:
Name:	Phone #:

Medical Information

Part(s) of the body injured:

Prior to this accident/incident, have you ever been hurt, suffered injury, or received treatment for the body part(s) listed above? Yes No

If yes, please provide the date of prior injury, type of injury, names of treating physician or practice group.

Description of Accident/Incident

What was the root cause of the incident? Ask why, and then ask why again. (e.g. Why? I slipped on scrap metal. Why? The work area was not cleaned up. Why? I was rushing to get project done and did not take time to clean up the work area.)

Suggested Corrective Actions

I hereby certify that the information I have provided is true and accurate. Any inaccurate or false statements may result in a delay in process of this claim. I further understand that this information may be used to determine whether the claim will be paid or denied.

Employee Name Signature Date / /