WORKFORCE SOLUTIONS

INCIDENT REPORT FORM

Use this form to report any workplace incident such as an injury, illness, or accident. Completed form must be returned **within 24 hours** by fax to **269-719-8840** or by email to **RiskMgmt@eg-us.com**.

This is documenting an: ☐ Injury ☐ Illness ☐ Accident

EMPLOYEE INFORMATION

Name:_____ Date of Birth:_____

Address:_____ City:_____ State: _____ Zip: _____

Phone Number(s): (_____) _____

DETAILS OF INCIDENT

Date:_____ Time: _____

Company/Position: _____

Specific Location of Incident: _____

Supervisor: _____

Witness(es): _____

DESCRIPTION OF EVENTS—BE SPECIFIC (DESCRIBE TASKS BEING PERFORMED/SEQUENCE OF EVENTS):

_____

_____

_____

_____

WHAT IS THE INJURY/ILLNESS? (IF APPLICABLE)

_____

_____

FACTORS THAT MAY HAVE LED TO YOUR INJURY/ILLNESS/ACCIDENT:

_____

_____

_____

TO BE COMPLETED IF MEDICAL TREATMENT IS NOT REQUESTED

I voluntarily choose to refuse medical treatment for this injury/illness/accident at this time.

_____
Employee Signature

TO BE COMPLETED IF MEDICAL TREATMENT IS REQUESTED

I hereby authorize all medical providers to release any pertinent medical information regarding this injury/illness/accident to EG Workforce Solutions for the sole purpose of injury management of this claim.

_____
Employee Signature

I verify that the above information is accurate and complete:

Signature of Employee:_____ Date: _____