Accident/Incident First Report Form

Note: In the event of serious injury, illness or death call Risk Manager immediately. **The supervisor/manager must complete and submit this form to RM@marionsc.org within 24 hours.**

Employee Information			
Name	Department		Phone
Date of Accident/Incident	Time of Accident/Incident a.m. ☐ p.m. ☐	Date Reported	Time Reported a.m. ☐ p.m. ☐
Reported to Whom	Location of Accident/Incident	Witnessed By	
Description of Accident/Incident			
Description of Injuries			
List Any Contributing Factors (if applicable)			
Did You Return To Work After The Accident/Incident? Yes ☐ No ☐	If **no**, date and time you left work: Date and time you returned to work:		
Signature	Date		
Witness Information (if applicable)			
Name	Department/Non-Employee		
Description of Accident/Incident			
Signature	Date		
Supervisor/Manager Completes			
Name	Was Employee Engaged In The Regular Course of Employment? Yes ☐ No ☐		
Description of Accident/Incident			
First Aid Administered? Yes ☐ No ☐	Employee Advised or Taken to Physician? Yes ☐ No ☐ Taken to Hospital? Yes ☐ No ☐ If **yes**, Hospital Name:		
What Could Have Been Done to Prevent Accident/Incident?			
What Action Have You Taken to Prevent a Recurrent or Similar Accident/Incident?			
Signature	Date		

Supervisor/Manager submit electronic form to: RM@marionsc.org