WESTERN NATIONAL INSURANCE
The relationship company

INCIDENT REPORT FORM

IMMEDIATELY REPORT ALL ACCIDENTS no matter how minor they may seem

Supervisors - Do not delay filing this information if the employee is unavailable to complete the form. Bottom portion of this form is to be completed by the Supervisor.

EMPLOYEE INFORMATION

Name:_____ Birthdate:___/___/___ Soc. Sec No. ____-___-_____
First MI Last

Address:_____ Zip_____ Phone: (____)____-_____
Street City State

Job Title:_____ Hire Date: ___/___ Marital Status: ☐ Married ☐Not Married
MO YR

Location where accident occurred: _____
Jobsite Address

Date of Accident:___/___/___ Time of Accident: _____ ☐AM ☐PM

Accident/Injury Reported to:_____on___/___/___.
Office/Supervisor Date

Did you lose work time? ☐ NO* ☐YES First Day of Lost Time: ____/____/____
Hours Lost on First Day: _____
Return to wok Date*: ____/____/____

Describe injury and body part involved: _____
Describe what you were doing and how the injury occurred: _____

Medical Status:
☐ No Medical Care Needed
☐ On-Site First Aid
☐ Off-site Medical Treatment

Physician/Clinic Name:_____ Initial visit:____/___/___

Employee Signature:_____ Today's Date: ____/____/____

*Report any additional or subsequent lost worktime to your Supervisor and Western National Insurance Immediately

SUPERVISOR INFORMATION:

Date Employer/Supervisor Notified of Incident: ___/__/___
What action has been taken to prevent a similar incident from recurring:

_____
_____
_____

Date Corrective Action was completed: ___/___/___

Supervisor's Signature:_____ Today's Date: ___/___/___