Prevention & Medical Care
To Help You Live Better, Longer.

Employee Incident Report

Section I – Report of Incident - To be completed by Employee

Employee Name:
Address: Town: Zip:
Position: Center: Supervisor:
Schedule, Hours Per day: Days per week:
Date of Incident: Time of Incident: Time work began:

Date Reported: Person reported to:
Witness: Was incident on Employer property:
Location of Incident: Department/Building Area:
Location of Incident if not on Employer property (address):

Please provide a brief description of incident:

Activity engaged in:

Substance/Equipment that may have contributed to the incident?:

Personal Protective Equipment (PPE) in use at time of incident?

Injury sustained:

Were you treated for injury: Location of treatment:

First Aid Clinic/Office visit Hospital Home Other

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Employee V : Date:

It is the employee's responsibility to identify at the time of seeking any treatment for this injury as work related and subject to worker's compensation coverage.

Once completed email this form to Humanresources@vmgma.com and copy your Supervisor.

Section II – Incident Review and Findings –
To be completed by Supervisor/Manager

Employee Name:

Description of Incident (detail what the employee was doing, how they were doing it, and what physical objects, tools, materials, chemicals, PPE, machines, structures or equipment were involved):

Why did the Incident happen? Report any details that may have contributed to the incident:

Source of Injury (objects, chemicals, medical equipment, office equipment, machinery, etc):

Describe corrective measures taken to address incident and to prevent recurrence of this type of incident: (training, equipment, modifications, etc)

Describe any materials, equipment, resources needed to prevent recurrance of this type of incident:

Has Employee returned to regular occupation?:
Date returned to work: Dates off due to injury:
Are there any accommodations or restrictions for the employee to return to work?:

Supervisor/Manager signature:

Once completed email this form to Humanresources@vmgma.com

Section III – To be completed by Human Resources

Date incident report received: Determined work related injury:

Date reported to MEMIC: Claim number:

Claim number given to employee: OSHA Form 300: ADP:

Forward to VP and Quality Mgr:

Is this a loss time Claim:

First day of total or partial incapacity to earn wages:

Fifth day of total or partial incapacity to earn wages:

Additional incident/injury review & findings (if applicable):

HR Signature: