INCIDENT REPORT FORM

This report is to be completed by the Worksite Supervisor within 24 hours of the incident. This form is a confidential, internal document and is not to be shared with persons who are not employees of the Department of Employment Services.

Host Agency: _____ Date of Incident: _____

Worksite : _____ Worksite Supervisor: _____

Name of person(s) involved:_____

Describe how incident occurred (Include facts only; exclude opinions and/or assumptions):

_____

_____

_____

_____

Witness(es): (Title: Supervisor, Youth, etc.) and Telephone number:

1.) _____ Phone: _____

2.) _____ Phone: _____

Other remarks:

_____

_____

Name of person completing this form: _____ Date: _____