**Arkansas Department of the Military**

 Incident Reporting Form

Name: Age: Employee ID No.:

Address:

City, State Zip:

Home Phone: Cell Phone:

Job Title:

Date of Accident: Time of Accident:

Location Where Incident Occurred:

 Type of Incident or Unsafe Condition: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Description of Incident (attach additional information if necessary):

Body Parts Injured:

Personal Protective Equipment (PPE) worn? Yes  No  N/A  If “YES”, what type of Personal Protective Equipment was used?

\_\_\_

\_\_\_

\_\_\_

Seat Belt Properly Used: Yes \_ No \_ N/A

\_\_\_

\_\_\_

\_\_\_

Opinion of Supervisor: Preventable \_ Non-Preventable Witness of Accident Phone

\_\_\_

\_\_\_\_

Employee Signature:

Supervisor (Please Print):

Supervisor Signature:

Supervisor Phone Number:

Date Completed: