



State of Oklahoma  
Office of Management & Enterprise Services  
Human Resources Department

Employee  
Incident Form

SECTION 1 – General Information		
Employee Name:		Employee ID:
DOB:	SSN:	Contact Number: (     )
Address:		
Job Title:		Average Weekly Wage: \$
SECTION 2 – Incident Details		
Date of Incident:	Time of Incident:     : <input type="checkbox"/> am <input type="checkbox"/> pm	Workday Began:     : <input type="checkbox"/> am <input type="checkbox"/> pm
Work Site:	Exact Location of the Incident:	
The employee was: <input type="checkbox"/> on break <input type="checkbox"/> on lunch <input type="checkbox"/> arriving to or leaving work for the day <input type="checkbox"/> performing the following tasks		
<input type="checkbox"/> Slip/Fall <input type="checkbox"/> Contusion <input type="checkbox"/> Cut/Puncture Wound <input type="checkbox"/> Chemical Injury <input type="checkbox"/> Strain/Sprain <input type="checkbox"/> Exposure <input type="checkbox"/> Other:		
Part(s) of body affected (be specific):		
Describe what happened, include details such as object(s) that caused the incident, how and why the incident occurred:		
Witnesses:		
If you have been treated by a physician, answer the following		
Name of the Physician:	Contact Number (     )	Date Treated:
Section 3 – Incident Reported To		
Direct Supervisor:		Title:
Other Supervisor:		Title:
Signature:	Date Reported:	Time reported:     : <input type="checkbox"/> am <input type="checkbox"/> pm
Report Prepared By:	Signature and Date:	
Human Resources:	Signature and Date:	
Section 4 – Outcome		
Describe Intervention and Outcome:		