Worker's Compensation Incident Report

*Please complete and submit this form **as soon as possible**. If more than one employee is injured, a separate Incident Report must be submitted for each employee. Please submit this with the Injury Chart.*

Employee Name: _____

Supervisor Name: _____

Date of Incident: _____ Time of Incident: _____

Location of Incident: _____

Witnesses: _____

Detailed description of ***incident and injury***: _____

_____

_____

_____

_____

_____

_____

List body part(s) injured: _____

_____

Was medical attention sought: ☐ Yes ☐ No

If yes, where was medical attention sought: _____

_____

If no medical attention was sought, we will file a "Report Only" claim.

Upon completion, please fax to HR at 830-796-8139 or email hgarcia@banderacounty.org
If you have any questions/concerns please call Sharon Dowda, Lynette Schroeder, or Harley Garcia at 830-796-4573.