FOR REPORTING PURPOSE ONLY

Augusta University

INCIDENT NOTICE ONLY

Instructions: Complete this form for record of incidences that **DO NOT** require medical treatment and fax to Benefits and Data Management at 706-721-1996. For occupational injuries **requiring medical attention or lost work days**, call the **Telephonic Reporting Center at 1-877-656-RISK (7475)** within 24 hours of knowledge of injury.

Section A: To be completed by Employee

Date incident reported: _____

Name of employee: _____ Office phone # _____

Job Title: _____

Social Security # _____

Date of incident: _____ Time of incident: _____

Description of incident (how, where, why?) _____

_____

_____

Type of incident (cut, scrape, burn, etc.) _____

Place of occurrence (provide address if possible) _____

Witness/es (Name/s and telephone #) _____

Supervisor's name _____ Telephone # _____

Person completing report _____ Telephone # _____

Date report completed _____

This form does not replace the WC-1, Employer's First Report of Injury.
***For all incident/accidents the supervisor must complete page 2.**
FOR INTERNAL USE - PERSONNEL RECORDS ONLY

Section B: To be completed by Supervisor

Date notified of injury: _____ Date of injury: _____

Supervisor Name: _____ Supervisor Office phone # _____

Name of Injured Employee: _____

Social Security # _____

Date of incident: _____ Time of incident: _____

After review of all facts, what was the hazardous condition, unsafe work practice or other root cause of the incident/injury? _____

_____

_____

What is recommended to prevent this type of incident/accident from occurring again? _____

_____

_____

Actions taken to ensure recommendations are considered (to include education): _____

_____

_____

Signature of Supervisor: _____ Date: _____