

# WACBD Incident Report Form

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Name of Person(s) Involved: \_\_\_\_\_

Employee Involved (If any): \_\_\_\_\_

Date of Event: \_\_\_\_\_ Location of Event: \_\_\_\_\_

Description of Event:

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Description of Injury:

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Actions Taken by Employees:

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Follow up Actions Required:

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Name of Employee: \_\_\_\_\_

Date: \_\_\_\_\_

**\*\*Once Investigation and Follow Up are Completed- Attach Documentation with this Report\*\***