WORKERS' COMPENSATION INCIDENT REPORT
(No Medical Treatment Required)

Name_____ Age___ Employee ID No. _____

Address_____
Street City State Zip

Home Phone __(____)_____Cell Phone__(____)_____

Job Title_____

Agency Name : University of Arkansas Community College at Batesville (HR Phone 870-612-165)
Mailing address: PO Box 3350, Batesville, AR 72503
Street Address: 2005 White Drive, Batesville, AR 72501

Date of Accident:_____ Time of Accident_____

Location where incident occurred:_____

Description of Incident_____

_____

Body Parts Injured: _____

Personal Protective Equipment (PPE) Worn? YES __ NO___

If "YES", what type of PPE was used?_____
_____

Seat Belt Properly Used: YES_____ NO ____ Not Applicable ___

Opinion of Supervisor _____Preventable ____Non-Preventable

Witness(es) of Accident Address(es)
_____ _____
_____ _____

Injured Employee Signature_____

Supervisor (Please Print)_____

Supervisor Signature _____

Supervisor Phone Number _____

Date Completed: _____