

GIRL SCOUTS WESTERN OKLAHOMA

INCIDENT REPORT FORM

IMPORTANT: All incidents, injuries, accidents, or workplace-related events must be reported to the Human Resources Department within **24 hours** of occurrence or as soon as reasonably possible, whether you desire treatment or not.

EMPLOYEE INFORMATION

Employee Name: _____

Job Title: _____

Department: _____

Date Report Completed: _____

Phone Number: _____

INCIDENT INFORMATION

Date of Incident: _____

Time of Incident: _____

Location of Incident: _____

DESCRIPTION OF INCIDENT

Please provide a detailed description of how the incident occurred, including the events leading up to the incident and any contributing factors.

NATURE OF INJURY OR INCIDENT

Describe any injury, illness, property damage, or other incident-related concerns.

BODY PART(S) AFFECTED (IF APPLICABLE)

WITNESS INFORMATION

Were there any witnesses? ☐ Yes ☐ No

If yes, please list all witnesses and contact information:

Witness Name: _____

Contact Information: _____

Witness Name: _____

Contact Information: _____

Witness Name: _____

Contact Information: _____

MEDICAL TREATMENT

Do you desire medical treatment for this injury/incident?

☐ Yes

☐ No

If YES:

Medical treatment must be coordinated through the Human Resources Department. The employee will be directed to an approved urgent care facility for an initial examination.

Please note:

- Medical treatment must be authorized through Human Resources.
- An initial evaluation will be conducted at an approved urgent care facility.
- A drug and alcohol screening may be administered in accordance with Girl Scouts Western Oklahoma policies and applicable laws as part of the workers' compensation and post-incident evaluation process.

Date HR Notified: _____

Urgent Care Facility Assigned: _____

IMMEDIATE ACTION TAKEN

Describe any immediate action taken following the incident.

CORRECTIVE OR PREVENTIVE ACTION RECOMMENDED

EMPLOYEE STATEMENT

I certify that the information provided in this report is true and accurate to the best of my knowledge.

Employee Signature: _____

Date: _____

HUMAN RESOURCES REVIEW

Date Incident Report Received: _____

Received Within 24 Hours? ☐ Yes ☐ No

Workers' Compensation Claim Needed? ☐ Yes ☐ No

Medical Referral Issued? ☐ Yes ☐ No

Drug Screen Administered? ☐ Yes ☐ No

Additional Follow-Up Required? ☐ Yes ☐ No

Comments:

HR Manager Signature: _____

Date: _____

Submit completed forms to the Human Resources Department within 24 hours of the incident. You can contact the Human Resources Department at 405-418-7981 or at kmoss@gswestok.org.