DFA Arkansas Department of Finance & Administration

Workers' Compensation Incident Report (No Medical Treatment Required)

Name:_____ **Age:** _____ **Employee ID No.:** _____

Address:_____

City, State Zip:_____

Home Phone: _____ **Cell Phone:** _____

Job Title: _____

Agency Name: _____

Agency Address: _____
Street, City, State Zip

Date of Accident: _____ **Time of Accident:** _____

Location Where Incident Occurred: _____

Description of Incident (attach additional information if necessary):

Body Parts Injured: _____

Personal Protective Equipment (PPE) worn? Yes ☐ **No** ☐ **N/A** ☐

If "YES", what type of Personal Protective Equipment was used?

_____

Seat Belt Properly Used: Yes ☐ **No** ☐ **N/A** ☐

Opinion of Supervisor: Preventable ☐ **Non-Preventable** ☐

Witness of Accident **Address**

_____ _____

_____ _____

Injured Employee Signature: _____

Supervisor (Please Print): _____

Supervisor Signature: _____

Supervisor Phone Number: _____

Date Completed: _____