

OGLE COUNTY
WORKER'S COMPENSATION INCIDENT REPORT

Name: _____

Phone Number: _____

Date of Incident: _____ Time: _____

Time You Notified Supervisor: _____

Person Notified: _____

Name of Witness: _____

Describe Incident: _____

Part of Body (Multiple Parts?) _____

Did You Receive First Aid? _____ Treated in ER? _____ Hospitalized? _____

Name & Address of Doctor or Treating Facility _____

I understand by signing this statement that I am verifying that all of the above statements are true and correct.

EMPLOYEE SIGNATURE

DATE

Reviewed By: _____
SUPERVISOR SIGNATURE

DATE