



## Workers' Compensation (Agency Name) Incident Notice Only

**Instructions:** For occupational injuries **requiring medical attention or lost workdays**, call the **Telephonic Reporting Center at 1-877-656-RISK (7475)** as soon as possible within 24 hours of knowledge of injury. Complete this form for the agency's record for all other injuries

Date incident reported by employee \_\_\_\_\_

Name of injured employee\_Office phone # \_\_\_\_\_

Job Title: \_\_\_\_\_

Social Security \_\_\_\_\_

Date of incident \_\_\_\_\_ Time of incident \_\_\_\_\_

Description of incident (how, where, why?)  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Type of injury (cut, scrape, burn, etc.) \_\_\_\_\_

Place of occurrence (provide address if possible) \_\_\_\_\_

County of occurrence (if possible) \_\_\_\_\_

Witness/es (Name/s and telephone #) \_\_\_\_\_

Was First Aid administered at time of incident? Yes, \_\_ No \_\_\_\_\_ What type? \_\_\_\_\_

Supervisor's name \_\_\_\_\_ Telephone # \_\_\_\_\_

Person completing report \_\_\_\_\_ Telephone # \_\_\_\_\_

Date Report completed \_\_\_\_\_

**This form does not replace the WC-1, Employer's First Report of Injury.  
FOR INTERNAL USE -  
PERSONNEL RECORDS ONLY**