# ADAIR COUNTY INCIDENT REPORT FORM

**Return this form to Human Resources within 24 hours of incident.**

**FAX 660-665-8406**

Date of incident: _____ Time: _____ AM/PM

Type of incident:

- Illness
- Injury
- Other

Name of person involved: _____

Address: _____

Phone Number(s):_____

Date of birth: _____

Social Security Number: _____

Marital Status _____

Number of Dependents _____

Date of Hire _____

Rate of Pay _____

Is person injured? ____ Yes ____ No

Type of injury: _____

_____

_____

_____

Where exactly did incident occur?

_____

_____

Details of incident: _____

_____

_____

_____

_____

Injury type (code) _____

Body Part (code) _____

Were there any witnesses? ____ Yes ____ No

Witnesses:

Name: _____

Address: _____

Phone Number: _____

Name: _____

Address: _____

Phone Number: _____

Injury requires physician/hospital visit? Yes ___ No _____

Did employee refuse medical treatment? Yes _____ No _____

Name of physician/hospital: _____

Address: _____

Physician/hospital phone number: _____

Name of Supervisor: _____

Phone Number of Supervisor:_____

Signature of person filling out report:

_____ Date_____