

INCIDENT REPORT

HUMAN RESOURCES
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701-628-8980

**MOUNTRAIL
COUNTY**

Complete this form to report incidents/illnesses that **DO NOT REQUIRE** medical treatment. (If you do need medical attention, and it is not an emergency, complete the paper version of the First Report of Injury.)

Contact your Supervisor (or the Risk Manager if supervisor is unavailable) immediately to notify him/her that an incident has occurred.

This form must be completed and submitted to Risk Manager within 24 hours of the incident occurring.

Employee Name

Date of Birth (M/D/YYYY)

Phone #

Injury Date (M/D/YYYY)

Time HH:MM

Body Part Injured

☐

Right

☐

Left

Nature of Injury (strain, cut, concussion, etc.)

Clearly describe HOW the Incident occurred

List any witnesses to the Incident

Employee Signature

Date

WAIVER OF MEDICAL TREATMENT

After completing this report, I declare that medical treatment is not necessary and I elect not to receive medical treatment *at this time*.

Employee Signature _____

Date _____

Clear all fields