Advanced Radiology Services PC

Incident Report

Name: _____ Incident Date and Time: _____

Job Title: _____ Work Location: _____

Witnesses: _____

Brief description of the incident: _____

_____

_____

_____

_____

Indicate body part(s) affected: _____

Did the incident cause injury? ◯ Yes ◯ No

Did you see a doctor? ◯ Yes ◯ No

Did you use any treatment for your injury, including taking medications? ◯ Yes ◯ No

If so, what type of treatment? _____

Did you go home during your work shift? ◯ Yes ◯ No

If yes, list the date and time you left your job: _____

Who did you report incident to? _____

On what date did you report incident? _____

_____ _____

Employee Signature Date

Received by: _____ Date received: _____

Submit this incident form to HR@advancedrad.com. Call Human Resources immediately if you need to seek treatment at 616-367-1228