Team EG Incident Report

Use this form to report any workplace incident such as an injury, illness, or accident. Completed form must be returned within 24 hours by fax to 269.719.8840 or by email to riskmgmt@eg-us.com.

I AM DOCUMENTING AN:

Illness

Injury

Accident

Employee Name: _____ **Date of Birth:** ___/___/___

Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Phone Number(s): ( ) _____

Incident Details

Date: ___/___/___ **Time:** ___:___ AM PM

Company and Position: _____

Specific Location of Incident: _____

Supervisor: _____ **Incident:** _____

Description of Events *Please be specific - detail tasks being performed and the sequence of events*

Description of Illness/Injury *If applicable*

Factors That May Have Lead to Illness/Injury/Accident

Medical Treatment is not Requested

I voluntarily choose to refuse medical treatment for this injury/illness/accident at this time.

Employee Signature: _____

Medical Treatment is Requested

I hereby authorize all medical providers to release any pertinent medical information regarding this injury/illness/accident to EG for the sole purpose of injury management of this claim.

Employee Signature: _____

I verify that the above information is accurate and complete

Employee Signature: _____ **Date:** ___/___/___