



Incident Reporting Form

Use this form to report any workplace accident, injury, incident, close call or illness.
Return completed form to Alliance Management: staff@asi-wi.com or fax to 262-677-3822

**ALLIANCE
SERVICES, INC**

This is documenting an:

Lost Time/Injury
 First Aid
 Incident
 Close Call
 Observation

Details of person injured or involved (to be filled in by person injured / involved if possible)

Person Completing Report: _____ Date: _____

Person(s) Involved: _____

Facility where incident occurred: _____

Event Details

Date of Event: _____ Location at facility: _____

Time of Event: _____ Witnesses: _____

Description of Events (Describe tasks being performed and sequence of events):

*If more space is required please use the back of this sheet

Was event / injury caused by an unsafe act (activity or movement) or an unsafe condition (machinery or weather)? Please explain:

TO BE COMPLETED ONLY IF LOST TIME/INJURY OR FIRST AID WAS REQUIRED	
Type of injury sustained:	
Cause of lost time/ injury or first aid:	
Was medical treatment necessary?	Yes _____ No _____ If yes, name of hospital or physician:

Signature of Alliance Employee: _____ Date: _____

Signature of Facility Supervisor: _____ Date: _____