

# Occupational Illness Incident Report

Report No.

Enter report number

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Date of Report

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Time of Report

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## Employee Information

Full Name

Employee full name

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Employee ID

ID number

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Department

Department

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Job Title

Job Title

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Supervisor

Supervisor Name

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Contact Information

Phone or Email

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## Incident Details

Date of Illness Onset

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Time of Onset

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Specific Location (where exposure/incident occurred)

e.g. Workshop, Lab, etc.

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Description of Incident / Exposure

Describe how and where the exposure or incident occurred

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Symptoms Observed

List all symptoms noticed

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Substance/Agent Involved (if applicable)

e.g. Chemical name, biological agent

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## Action Taken

### First Aid Provided

Describe first aid or treatment given

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### Medical Attention Required?

Yes/No, specify details

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### Time Off Work Required?

Yes/No, specify details

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### Corrective Actions Taken

Describe steps taken to prevent recurrence

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## Reporting & Verification

### Reported By

Name

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### Date

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### Supervisor Review

Name

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### Date

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### Additional Comments

Optional

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## Important Notes

- Complete this report as soon as an occupational illness is identified or suspected.
- Provide detailed and factual information to ensure accurate recordkeeping and effective follow-up.
- Maintain confidentiality of employee health information as required by applicable regulations.
- Keep copies of this report for both employer and employee records.
- Follow up on corrective actions and monitor for recurrence.