

Occupational Illness Incident Report

Report No.

Enter report number

Date of Report

Time of Report

Employee Information

Full Name

Employee full name

Employee ID

ID number

Department

Department

Job Title

Job Title

Supervisor

Supervisor Name

Contact Information

Phone or Email

Incident Details

Date of Illness Onset

Time of Onset

Specific Location (where exposure/incident occurred)

e.g. Workshop, Lab, etc.

Description of Incident / Exposure

Describe how and where the exposure or incident occurred

Symptoms Observed

List all symptoms noticed

Substance/Agent Involved (if applicable)

e.g. Chemical name, biological agent

Action Taken

First Aid Provided

Describe first aid or treatment given

Medical Attention Required?

Yes/No, specify details

Time Off Work Required?

Yes/No, specify details

Corrective Actions Taken

Describe steps taken to prevent recurrence

Reporting & Verification

Reported By

Name

Date

Supervisor Review

Name

Date

Additional Comments

Optional

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.