



INCIDENT REPORT FORM

This form is a confidential, internal document and is not to be shared with persons who are not employees of the Department of Employment Services.

Host Agency: _____ Date of Incident: _____
Worksite: _____ Worksite Supervisor: _____
Name of person(s) Involved: _____

Describe how the incident occurred (Include facts only; exclude opinions and/or assumptions):

Witness(es): (Title: Supervisor, Youth, etc) and Telephone number:

1. _____ Phone: _____
2. _____ Phone: _____

Other remarks:

Name of person completing this form: _____ Date: _____