RPSystems

Incident Report

Report #: _____ **Date of Report:** _____/_____/_____

Incident Information

Date of Incident: _____/_____/_____ **Time:** _____:_____ ☐ AM ☐ PM

Location: _____ (specific area within restaurant)

Type of Incident: (check all that apply)

- ☐ Employee Injury
- ☐ Slip/Trip/Fall
- ☐ Cut/Laceration
- ☐ Food Safety Issue
- ☐ Theft
- ☐ Equipment Malfunction
- ☐ Customer Injury
- ☐ Burn
- ☐ Allergic Reaction
- ☐ Property Damage
- ☐ Altercation/Conflict
- ☐ Other: _____

Injured/Affected Party Information

Name: _____ ☐ **Employee** ☐ **Customer** ☐ **Vendor** ☐ **Other**

Phone: (_____) _____-_____ **Email:** _____

Address: _____

If Employee - Position: _____ **Hire Date:** _____/_____/_____

Incident Description

Describe exactly what happened: (who, what, when, where, how)

Injury/Damage Details

Nature of injury or damage:

- ☐ Bruise/Contusion
- ☐ Cut/Laceration
- ☐ Fracture/Break
- ☐ Eye Injury
- ☐ Illness
- ☐ Sprain/Strain
- ☐ Burn (1st/2nd/3rd degree)
- ☐ Back Injury
- ☐ Allergic Reaction
- ☐ Property Damage

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Medical Treatment

Was medical treatment provided? ☐ Yes ☐ No

First aid given on-site: ☐ Yes ☐ No **By whom:** _____

Describe first aid provided:

_____

EMS/911 called: ☐ Yes ☐ No **Time called:** _____:_____

Transported to hospital: ☐ Yes ☐ No **Hospital name:** _____

Refused medical treatment: ☐ Yes ☐ No

Witnesses

Name	Employee/Customer	Phone	Statement Taken?
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No

Contributing Factors

What factors may have contributed to this incident?

- ☐ Wet/slippery floor
- ☐ Obstructed walkway
- ☐ Improper training
- ☐ Lack of PPE
- ☐ Fatigue
- ☐ Poor lighting
- ☐ Defective equipment
- ☐ Failure to follow procedure
- ☐ Rushing/time pressure
- ☐ Unknown

Other factors:

_____

Corrective Actions Taken

Immediate actions taken to address the situation:

Actions to prevent future occurrences:

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Documentation

Photos taken: ☐ Yes ☐ No **Number of photos:** _____

Video footage available: ☐ Yes ☐ No **Footage preserved:** ☐ Yes ☐ No

Police report filed: ☐ Yes ☐ No **Report #:** _____

Insurance notified: ☐ Yes ☐ No **Date:** _____/_____/_____ **Claim #:** _____

Report Completed By	Title/Position	Date
Manager/Owner Review	Date Reviewed	Follow-up Date

Important: Complete this form within 24 hours of incident. Keep original on file for minimum 5 years. Provide copies to insurance and HR as required. All employee injuries must also be reported to workers' compensation carrier. Do not admit liability or make statements about fault.