ACCIDENT / INCIDENT REPORT FORM – COMPLETE WITHIN 24 HOURS OF INCIDENT

DATE OF INCIDENT: _____/_____/_____ TIME OF INCIDENT: _____ AM / PM

PRINT Name of injured employee:							
Employee ID #		Job Title					
Date of Birth		Male / Female					
Department		Supervisor's Name					
Employee's work schedule / Hours	SUN	MON	TUES	WED	THURS	FRI	SAT

Employee Address			
Telephone	Work #	Home #	Cell #
Email			

INCIDENT INFORMATION	
Location of Incident (specify casino or other property and location within property)	
Description of injury and body parts affected	
Provide a chronological description of the incident (use back of sheet if necessary):	
Who was notified of the incident?	
Were there any witnesses? If so, please provide names and job positions	
Were there any hazards which may have contributed to the incident? If so, please provide details	
Was medical attention requested?	YES or NO
Was medical attention received?	YES or NO
Name of physician / hospital	
Address of physician / hospital	
Physician / hospital telephone	

Signature of injured employee		DATE:
If person completing form is not the employee then please PRINT name of person filing report, SIGN and DATE	PRINT NAME	
	SIGNATURE	
	DATE	

Submit completed form within 24 hours of incident to Sarah Escaleira, Benefits Manager, Human Resources, at sarah.escaleira@turningstone.com. For additional information please call the Benefits Team, at 315-361-8600.

REV: 20190626