YUKON WORKERS' COMPENSATION HEALTH AND SAFETY BOARD

IMMEDIATE INCIDENT REPORTING FOR THE WORKER

Name: _____ Date: _____

Description of what happened or of the condition:

_____

_____

_____

_____

Location: _____

Date of occurrence IF other than today: _____

Did you take any action?

Yes What? _____

No What? _____

Name of your Supervisor _____

Please Submit completed form to your supervisor.