DEPARTMENT OF CORRECTIONS
EMPLOYEE INCIDENT NOTICE

SOP IVO04-0002
Attachment 1
5/01/05

Instructions:
Complete this form for occupational and other injuries requiring medical attention or lost workdays. For **occupational** injuries, call Teleclaim at 877-656-7475 **within 24 hours** or as soon as practical after the injury.

EMPLOYEE INFORMATION

Name of injured employee:	Job Title:
Social Security #:	Employee ID #:
Work unit:	Office telephone #:

INCIDENT INFORMATION

Date of incident:	Time of incident:	Place of incident (provide address if possible):
Type of incident (Cut, burn, scrape, etc.):		Body part(s) affected (be specific, Left eye, etc.):
Description of incident (How, where, why?):		
Witness [Name(s) and telephone #]:		
Was first aid administered at the time of the incident? ☐ YES ☐ NO If YES, describe the type/by whom:		

INCIDENT REPORT INFORMATION

Name of person completing incident report:	Telephone #:
Date employee reported the incident:	Date report completed:

SUPERVISOR INFORMATION

Name:	Telephone #:

This report does **not** replace the WC1- Employer's First Report of Injury. This is for supervisor's records for **INTERNAL USE ONLY. Do not submit to DOAS, Risk Management.**

Record Retention: Retain in local medical file until replaced by the official copy of WC1-Employer's First Report of Injury.