

ARKANSAS FORESTRY COMMISSION
ACCIDENT/INJURY INCIDENT REPORT

AFC Unit _____

Employee Name and Title: _____

Date of Injury _____ Time of Injury _____

Location where injury occurred _____

Part of body injured _____

Was safety equipment provided/worn? Yes _____ No _____

Briefly explain how injury occurred _____

List witnesses to incident _____

Did your supervisor ask you if you wanted to see a doctor? Yes _____ No _____

Did you decline to see a doctor? Yes _____ No _____ If no, ask supervisor for set of
Workers Compensation forms to complete.

Date

Employee Signature

Date

Supervisor Signature

Employee: You may retain a copy of form.

Supervisor: Please retain a copy for your records and forward original to Little Rock Human
Resources.