Iowa OSHA
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FOR OFFICE USE ONLY

Received by			
Sent by	◯ Fax	◯ Phone	◯ Email
Date	Time	◯ am	◯ pm
Inspection Planned	◯ Yes	◯ No	
Inspection #	CSHO		
Autopsy performed	◯ Yes	◯ No	

Incident Report

Enter # of affected employees	0	**Fatality**	0	**Hospitalization**	0	**Loss of an eye**	0	**Amputation**	
Business name						Federal ID #			
Mailing address		City				State		Zip	
Phone	( ) -	Fax	( ) -	Email					
Business activity		NAICS				# of employees			
Ownership	◯ Private	◯ Local Government		◯ State Government		◯ Federal Agency			
Your name						Job title			
Phone	( ) -	Fax	( ) -	Email					
Event address	or ☐ Same as mailing address								
City		State				Zip			
Date of accident		Time		◯ am	◯ pm	Phone	( ) -		
Name of affected employee						Social Security #			
DOB		Time began work		◯ am	◯ pm	Occupation			
Name of affected employee						Social Security #			
DOB		Time began work		◯ am	◯ pm	Occupation			
Description of incident									

If fatality, next of kin information	Name				
Address		City		State	Zip
Phone	( ) -	Relationship			