

DEPARTMENT OF DEFENSE
INCIDENT NOTICE ONLY

Instructions: For occupational injuries requiring medical attention or lost work days.
Complete this form and submit to Ms. Venus Askew at 1388 First Street, Bldg 840, Dobbins
ARB, GA 30069 as soon as possible within 24 hours of knowledge of injury. (Send copies to: BDE CDR;
BDE EO; BDE Safety Officer).

Date incident reported by soldier.

Name of injured soldier _____ Office/home Phone#

_____ Position Title: _____

Social Security # _____

Date of incident _____ Time of incident _____

Time Workday began: _____ Hours worked: _____

Description of incident? What was the soldier doing at the time of injury?

How:

Where:

Why:

Type of injury (cut, scrape, burn, etc.) _____

Place of occurrence (Provide physical address is possible)

County of Injury: _____

Witness/es (Name/s and telephone #

Was First Aid administered at time of incident? Yes ___ No ___ What Type?

Supervisor's name _____ Telephone #

Person Completing report _____ Telephone # _____

REPORTING OF INJURIES CONTINUED

Date Report completed

DOD INCIDENT NOTIFICATION FORM

Date appointed into GaSDF _____

Date of Birth _____

Marital Status of Injured Soldier

of dependents of Injured Soldier

Injured Soldier's Home Address _____

Was Lodging Provided _____ Cost _____

Is Soldier Retired? Yes ___ No ___

If not retired Name and Address of Soldier to include Telephone #

Was Soldier taken by Ambulance to the hospital:

Did Soldier take him/herself to the Hospital:

Name of Hospital or Clinic to include mailing Address: _____

Name of Attending Physician:

Phone # of Hospital/Attending Physician:

Has Injured Soldier Returned to work: