CONTRACTOR INCIDENT REPORT FORM

NOTE: To be completed by Project Manager or Facilities Manager.
Completed form to be returned to Compliance Director within 24 hours of Incident.

Date of Report: _____

Injured Party: _____

Employer: _____

Site: _____ Site Location: _____

Report Prepared By: _____

Signature: _____ Title: _____

1. ACCIDENT/INCIDENT CATEGORY (check all that applies)
___Injury ___ Illness ___Near Miss ___ Property Damage ___ Fire ___ Chemical Exposure

___ On-site Equipment ___ Motor Vehicle ___ Electrical ___ Mechanical ___ Spill

___ Other (Specify:_____)

2. DATE AND TIME OF ACCIDENT/INCIDENT: _____ _____ (AM/PM)

In a narrative report of the Accident/Incident, please identify the actions leading to or contributing to the accident/incident and the actions following the accident/incident.

3. WITNESS TO ACCIDENT/INCIDENT:

Name: _____ Company: _____

Address: _____ Address: _____

Phone No.:_____ Phone No.: _____

Name: _____ Company: _____

Address: _____ Address: _____

Phone No.: _____ Phone No.: _____

4. INJURED - ILL:

Name: _____

Address: _____ Age: _____

Length of Service: _____ Time on Present Job: _____

Time/Classification: _____

5. SEVERITY OF INJURY OR ILLNESS:

____ Disabling ___ Non-disabling ___ Fatality____ Medical Treatment ___ First Aid Only

6. ESTIMATED NUMBER OF DAYS AWAY FROM JOB: _____

7. NATURE OF INJURY OR ILLNESS: _____

8. CLASSIFICATION OF INJURY (Check all that apply):

__ Abrasions _____ Dislocations ____ Punctures ____ Bites _____ Faint/Dizziness ____ Radiation Burns

__ Blisters _____ Fractures ____ Respiratory Allergy ____ Bruises _____ Frostbite ____ Sprains

__ Chemical Burns _____ Heat Burns ____ Toxic Resp. Exposure ____ Cold Exposure

__ Heat Exhaustion __ Toxic Ingestion __ Concussion _____ Heat Stroke ____ Dermal Allergy

__ Lacerations

- Part of Body Affected: _____
- Degree of Disability: _____
- Date Medical Care was received: _____
- Where Medical Care was received: _____
- Address (if off-site): _____

9. PROPERTY DAMAGE:

Description of Damage: _____

Cost of Damage: $ _____

10. ACCIDENT/INCIDENT ANALYSIS: Causative agent most directly related to accident/incident (Object, substance, material, machinery, equipment, conditions)

- Was weather a factor?

- Unsafe mechanical/physical/environmental condition at time of accident/incident (Be specific):

- Personal factors (Attitude, knowledge or skill, reaction time, fatigue, hobbies):

11. ON-SITE ACCIDENTS/INCIDENTS:
Level of personal protection equipment required in Site Safety Plan (if applicable):

- Modifications:

- Was injured using required equipment?

- If not, how did actual equipment use differ from plan?

12. ACTION TAKEN TO PREVENT RECURRENCE: *(Be specific. What has or will be done? When will it be done? Who is the responsible party to insure that the correction is made?*

13. ACCIDENT/INCIDENT REPORT REVIEWED BY:

Name Printed: _____ Signature _____

14. OTHERS PARTICIPATING IN INVESTIGATION:

Signature _____ Title _____

Signature _____ Title _____

Signature _____ Title _____