HSE Incident Reporting Forms

Pages Included in this report: ☐General Information ☐ Company Vehicle ☐ Non Company Vehicle ☐ Injury / Illness ☐ Environmental ☐ External Assessment ☐ Witness / External Investigator or Adjuster ☐ Property / Equipment Damage

Section 1 General Information

1.1 Incident Type, Date and Time Information

Incident Type *Check any that apply*

☐ Incident ☐ Radiation Involved
☐ Near Miss ☐ Explosives Involved

Primary Incident Type

☐ Injury Illness
☐ Vehicle
☐ Environmental
☐ Property / Equip Damage
☐ External Assessment

Secondary Incident Type(s)

☐ Injury Illness
☐ Environmental
☐ Property / Equip Damage
☐ External Assessment

Risk Assessment

☐ Risk Assessment Performed Prior to Incident?

☐ Was Risk Assessment Documented?

Date and Time Information

Note: Date Format 01-JAN-99 Time Format 24 hr: 18:00

	Date	Time
Occurrence Date and Time:		
Date and Time Reported:		
Incident Reported By:		
Supervisor's Name in charge of work activity at time of incident:		
Person Completing Form:		
Person Completing Form Phone Number:		

1.2 Incident Location & Responsible Business Unit

Occurrence Site (describe where the incident occurred)	Location Type:
Region:	
Country and State / Province (If U.S., include county)	

1.3 Description of Incident

Brief Description:
Detailed Description

Section 2 Vehicle Incident Details

Note: Any vehicle where a company employee is driving, is considered a "company vehicle" If more than one company vehicle is involved, make copies of this page.

Check any that apply:

☐ Company Vehicle Involved (Complete 2.1) ☐ Non Company Vehicle Involved (Complete 2.2)

2.1 Company Vehicle

Vehicle Information

Vehicle VIN	Vehicle Make
Company Number	Vehicle Model
License Number:	Vehicle Type
Vehicle a Rental? ☐ Yes ☐ No If Yes, Company:	

Driver License No. ______________ State / Country ______________

Expiry Date d/m/y ______________ City, State Nearest the place where the incident occurred: ______________

Company or Non Company Driver and/or passenger information

Company Employee? Y/N		Last Name	First name	Emp. Number	Seat Belt Worn?
Driver:					☐ Yes ☐ No
Passenger 1					☐ Yes ☐ No
Passenger 2					☐ Yes ☐ No
Passenger 3					☐ Yes ☐ No
Passenger 4					☐ Yes ☐ No
Passenger 5					☐ Yes ☐ No

Damage to Company Vehicle:

Recordability: ☐ Company Reportable ☐ Company Recordable ☐ DOT Recordable (U.S. Only) ☐ Documentation Only

Vehicle weight more than 10,000 lbs (4550 kg)? ☐ Yes	Hazardous Chemical Spilled? (other than fuel from the fuel tanks) ☐ Yes
Our Vehicle transporting Hazardous Material? ☐ Yes	Any party receive medical treatment away from the scene? ☐ Yes
Vehicle designed to transport 16 + passengers? ☐ Yes	Were there any fatalities? ☐ Yes
Company Vehicle Towed From Scene? ☐ Yes	
Non Company Veh Towed From Scene? ☐ Yes	

Describe Damage to Company Vehicle:

Drugs & Alcohol Information

Was a drugs & alcohol test administered?	☐ No	☐ Yes - within 2 hours ☐ Yes within 32 hours (drugs only)	☐ Yes - within 8 hours
If no drugs & alcohol test was administered, give details as to why not:			

Section 2 Vehicle Incident Details - *Continued*

2.2 Non Company Vehicle *If more than one non-company vehicle was involved, make additional copies of this page.*

Vehicle Information

Vehicle VIN	Vehicle Make
License Number:	Vehicle Model
License Jurisdiction:	Vehicle Type
Non Company vehicle towed from scene? ☐ Yes Medical treatment away from Scene? ☐ Yes	Any indications of drugs and/or alcohol? ☐ Yes

Non Company Vehicle - (Driver Information)

Last Name:	First Name:	
Address:		
Drivers License Information		
Number	State / Country	Expiry Date (01-JAN-99)
Insurance Company	Address and Phone Number	Policy Number

Injury details of non-company persons

Name:	Nature of Injury	Address / Phone Number
Name:	Nature of Injury	Address / Phone Number
Name:	Nature of Injury	Address / Phone Number

Section 3 Injury / Illness Incident Details

Check all that apply

☐ Company Employee (Complete 3.1)

☐ Member of Public (Complete 3.3)

☐ Client Employee
☐ Sub Contractor Employee
☐ Casual / Temporary / Contract Employee
(Complete 3.2)

3.1 Company Employee Details *For Additional Injuries associated with this incident, make copies of this page.*

Recordability: *Check applicable recordability*

☐ First Aid Case (Complete Justification) ☐ Non-Recordable Medical (Complete Justification) ☐ Restricted Work Case ☐ Lost Time Case ☐ Medical Case ☐ Fatality Case	☐ Non-Occupational Restricted Work Case ☐ Non-Occupational Lost Time Case ☐ Non-Occupational Medical Case ☐ Non-Occupational Fatality Case

Injured Party Information

Last Name:	First Name:	Emp. Number:
Job Task:	Job Activity:	
Body Part(s):	Nature of injury:	
Body Part(s):	Nature of injury:	
Additional Comments:		

Justification for "*First Aid*" or "*Non Recordable Medical*" Recordability Class

☐ Administering Tetanus Immunization
☐ Cleaning, Flushing or Soaking Wounds on the Surface of the Skin
☐ Drilling Fingernail / Toenail to Relieve Pressure or Draining Fluid from a Blister
☐ No Treatment Given (Diagnostic Only)
☐ Remove Foreign Bodies from the Eye using only Irrigation or Cotton Swab
☐ Remove Splinters / Foreign Material from Areas Other Than the Eye by Simple Means
☐ Use of Nonprescription Medication at Nonprescription Strength
☐ Use of Hot or Cold Therapy
☐ Using any Non Rigid Means of Support (i.e. Elastic Bandages)
☐ Using Finger Nail Guards
☐ Using Massages
☐ Using Wound Coverings such as Bandages, Gauze Pads or Butterfly Bandages

Note: In order to meet new US OSHA recordability requirements for 2002, this additional filed has been added to the Incident database. This field MUST be completed for any incident occurring after the 31 December 2002, where the Recordability of Injury / Illness is listed as First Aid or Non Recordable Medical.

Drugs & Alcohol Information

Was a drugs & alcohol test administered?	☐ No	☐ Yes - within 2 hours ☐ Yes within 32 hours (drugs only)	☐ Yes - within 8 hours
If no drugs & alcohol test was administered, give details as to why not:			

Section 3 Injury / Illness Incident Details - *Continued*

3.2 Other Involved Parties

Check applicable person type: **Note:** ***for additional parties, make copies of this page***
☐ Sub Contractor Employee ☐ Client Employee ☐ Casual / Temporary / Contract Employee

Injured Party Information

Last Name:	First Name:	Company:
Phone	Address	
Job Task:	Job Activity:	
Insurance "Causes":		
Body Part(s): ☐ Left ☐ Right	Nature of injury:	
Body Part(s): ☐ Left ☐ Right	Nature of injury:	
Additional Comments:		

3.3 Member of Public Injured Party Details

Last Name:	First Name:	Task at time of incident:
Phone	Address	
Body Part(s): ☐ Left ☐ Right	Nature of injury:	

Section 4 Environmental Incident Details

Check all that apply:

Agent	**Medium**	**Effect**
☐ Substance	☐ Air	☐ People
☐ Explosion	☐ Ground Water	☐ Vegetation
☐ Light	☐ Soil	☐ Animals
☐ Noise	☐ Surface Water	☐ Structures
☐ Radiation		☐ Equipment
☐ Vibration		☐ Materials

Substance Information

Name of Substance *(Specify Material Name)*	Amount	Unit of Measure

Describe Response Details

Section 5 External Assessment

Check any that apply

☐ Notice of Violation	☐ Audit	☐ Self Reported	☐ Other
☐ Administrative Order	☐ Inspection	☐ Regulatory Investigation	

Describe the Assessment, If there are specific comments made by anyone, include those in Section 6, Witnesses / External Investigator or Adjuster.

Section 6 Witnesses / External Investigator or Adjuster

Person 1

Last Name:	First Name:	Company:
Phone	Address	
Comments		

Person 2

Last Name:	First Name:	Company:
Phone	Address	
Comments		

Section 7 Property / Equipment Damage

Who Owns the Property / Equipment: ☐ Company ☐ Client / Contractor ☐ Third Party	**Equipment type:** *Examples: Tank, Building, Trailer, Fork Lift etc*
Type of Damage ☐ Structural ☐ Mechanical ☐ Process Failure ☐ Theft ☐ Sabotage ☐ Fire ☐ Natural Causes (Earthquake, Flood, etc.)	
Description of Damage: *Provide details of the Type of Property and Equipment (with serial numbers etc., if applicable), and describe what happened and the extent of damage. If possible, provide an estimate of the cost of the damage.*	