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.: _____________________________

   Name: ____________________________ Company: ________________________________
   Address: __________________________ Address: ________________________________
   Phone No.: ________________________ Phone No.: _____________________________

   Name: ____________________________ Company: ________________________________
   Address: __________________________ Address: ________________________________
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   Address: __________________________ Address: ________________________________
   Phone No.: ________________________ Phone No.: _____________________________

   Name: ____________________________ Company: ________________________________
   Address: __________________________ Address: ________________________________
   Phone No.: ________________________ Phone No.: _____________________________

   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 _______________________________