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: Title:

Signature:

1. **ACCIDENT/INCIDENT CATEGORY** (check all that apply – Double click and select "CHECKED")

☐ 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: Phone number:

Name: Company:

Address: Phone number:

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 **-** Double click and select "CHECKED")

☐ 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

Name Printed: Signature

14. **OTHERS PARTICIPATING IN INVESTIGATION:**

Signature Title

Signature Title

Signature Title