	• •	I	ncident Report	-							
Injury, Damage t	o property , or	Near Miss <i>(cir</i>	cle one)	Fax to: '							
Subcontractor's name (if not employee):											
Damage to: equipment, new construction work, existing facility, vehicle, other											
		the second s	M.I.								
Employee's Last Na	ine, rii	SUNAME	Wr.1.								
Injury Date	Start Time	Injury Time	Witnesses	Any Lost Time?							
Trade/Occupation	Jobsite #	Where did the incid	ent occur?	•							
Specific type of work	at time of incider	nt (i.e. demolition)									
			incident? How was he/she doin								
trigger the incident?	What body part s	specifically was invo	lved?) Continue on back if	necessary>>>							
		······································									
Data Insident Banar	tod	Suponvisor it v	vas reported to:								
Date Incident Repor	led.		vas reported to.								
Circle Type of incid Exposure to, Contac			level, Fall to same level, Struck	/Cut by, Struck/Cut on,							
What caused or con		and the second sec		above unsafe action(s)? Circle							
condition(s)? Circle	all that apply.		all that apply.								
1. Caused by employ	yee 9. Expos	ure to corrosion	1. Unaware of hazard	8. Fatigue influenced action							
2. Defective: normal		sure to heat/cold	2. Didn't know safe procedure 9. Defective vision								
3. Defective: abuse/			3. Low-level job skill 10. Defective hearing								
4. Safety inspection			4. Ignored known hazard	11. Other physical condition							
5. Poor Housekeepin	-	d by other worker other than above:	5. Tried to save time	12. Cause other than above:							
 Illumination deficient Faulty design 	ency 14. Cause	other than above.	6. Tried to avoid effort								
8. Faulty constructio	n 15 Unable	to determine	7. Illness influenced action	13. Unable to determine							
			t recurrence? Circle all that ap	nly							
1. Reinstruction of p		8. Standardized	-	of safer materials/supplies							
2. Preventative instr	• •		/device installed 16. Improved illumination								
3. Discipline of person(s) responsible 10. Protective equipment required 17. Improved ventilation											
4. Job safety analysis ordered 11. Tool/equipment repaired/replaced 18. Improved temperature control											
5. Job reassignment of employee12. Improved storage19. Reduces noise/vibration6. Improved inspection procedure13. Eliminated congestion20. Correction other than above7											
6. Improved inspection procedure 13. Eliminated congestion 20. Correction other than above											
Improved cleanup p		14. Improved desig	n/construction (desc	ribe below)							
Describe details of c	corrective action ta	aken or planned:									
	······································										
Medical care? Yes	, No. If yes, Wha	t clinic/hospital:									
Completed by:				Date:							
IMMEDIATE calls r may result in Lost			and (damage likely to exceed \$500	 for any injury that 0. 							
		· · · · · · · · · · · · · · · · · · ·									

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This entire form must be completed.

SUPERVISOR'S INCIDENT REPORT

Injury (work related)																		
Employee Name (First, Middle, Last) Social Security Nu								ber	Sex Emplo					ee Home Telephone Number				
						-		Male Female				- - -						
Employee's Street Address												State		Zip				
Age Birthdate Job Title										1	Depa	rtment						
	Mo.	Day Y	r.															
											_							
Employee's		Start Time	End T	ime	Hrs. Per D	ay	Hrs. Per	Wk.	Days F	Per W	<i>I</i> K. 1	Normal	Full-Time	Start '	Time	End T	ime	
Scheduled Work												Schedule for						
Week When Injured AM												Injured's Work		AM PM		AM PM		
Injury Date Hour o		Hour of Day	ay Last Day Worked		d	Start Da	te			No Lo	Lost Time							
Mo. Day Yr.		1	Mo. Day Yr.		Mo.	Day					d to Work		Mo.	Day	Yr.			
AM PM												te of Retur	m		1			
			_	_	_													
Did employe	ee seek m	edical attentio	n? [] Yes	□No	If yes	s, name of	f treati	ng physio	cian:								
Name of cli			•			-												
will the emp	bloyee con	nplete a drug	screeni	ngr														
					Yes	No												
1.		(Attach witnes						2.										
	. <u></u>							Z						·				
Injured Emr	lovoo'e et	atement of wh	at hann	honod	(Identify circ	himei	ances an	d oqui	oment in	volvo	d١							
Injured Employee's statement of what happened. (Identify circumstances and equipment involved.)																		
																-		
How could this incident have been prevented?																		
·																		
<u> </u>																		
What correct	ctive action	n has been tak	ken?															
Mhat is the	iniun <i>u</i> illing	ss? (Be spec	ific)															
Part of Bod				•			Type of	tnium	,									
Eye			•															
Head		Foot					Bruis											
□ Neck		Wrist					Forei											
Back		Hand					Burn		,									
Arm		Toes					Breat											
Shoulder		Ankle					Sprai		in									
Fingers		Elbow					Expo	sure										
🗋 Leg		Trunk (Other than back)				🗌 Repe	etitive l	Motion										
🗌 Knee		Cther					C Othe	r										
							. <u></u>											
I holicus #	4 tha	on to the she		otions		ha	of of much		-									
i pelleve (US	it the arisy	vers to the abo	we que	อนบทร	aie 11 UE 10 11	ne De	ist of my K	IUWIE	uye.									
Employee's	Signature						_ Date	, _										
Supervisors	Signature	e e					Date	•										
		-					_	_	Notified		-							

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