INCIDENT INVESTIGATION REPORT

~~ Complete and Send Incident Report, Job Analysis, Photos and Attachments within 8 hours! ~~
Fax:_____ ~~ Email: _____
If Medical Attention is needed (and is not available on site) call _____.

OCIP? ☐ Yes ☐ No	Form completed by (print): Title: Phone #: Signature:	Report Date:
Job #	Project Name:	Project Address:
Project Manager: Project Manager Phone:	Foreman: Foreman Phone:	
Date of Incident:	Time of Incident: _____ ☐ AM ☐ PM	Project Phone: Project Fax:
Name of Injured / Involved:	☐ Male ☐ Female	Date of Birth:
Phone # ☐ Home ☐ Cell	Address:	
Occupation/Classification:	Office Use Only: DOH:	Time started work: _____ ☐ AM ☐ PM
Hours of sleep within last 24:		

☐ Incident Only – No Injury
☐ First Aid Only
☐ Illness / Injury
☐ Near Hit
☐ Property Damage
☐ Fatal

Exact Location of Incident: (i.e. Loading dock, 1st floor, roof, parking lot, etc.)

Was employee treated ☐ On site ☐ Off site
If off site, name of facility:

Where was drug and alcohol screen performed?

Treated by:	Address of Treatment Facility:	Phone # of Treatment Facility:

Type of Injury/Illness:

- ☐ Abrasion
- ☐ Amputation
- ☐ Asphyxiation
- ☐ Burn
- ☐ Concussion
- ☐ Contagious Disease
- ☐ Contusion
- ☐ Crushing
- ☐ Dermatitis
- ☐ Dislocation
- ☐ Electric Shock
- ☐ Foreign Body
- ☐ Fracture
- ☐ Freezing
- ☐ Hearing Loss / Impairment
- ☐ Heat Illness
- ☐ Infection
- ☐ Inflammation
- ☐ Laceration
- ☐ Multiple Injuries
- ☐ Myocardial Infarction
- ☐ No Physical Injury
- ☐ Poisoning
- ☐ Puncture
- ☐ Radiation
- ☐ Repetitive Trauma
- ☐ Respiratory Disorder
- ☐ Sprain
- ☐ Strain
- ☐ Other (specify)

Cause/Source of Injury/Illness:

- ☐ Absorption / Ingestion / Inhalation
- ☐ Animal / Insect
- ☐ Bodily Reaction
- ☐ Burn / Scald
- ☐ Caught In / Under / Between
- ☐ Contact w/Electrical Current
- ☐ Cumulative
- ☐ Cut / Puncture / Scrape
- ☐ Dusts / Gases / Fumes / Vapors
- ☐ Explosion / Flare Back
- ☐ Exposure
- ☐ External Contact
- ☐ Fall / Slip / Trip
- ☐ Fire / Flame
- ☐ Motor Vehicle Accident
- ☐ Overexertion
- ☐ Radiation
- ☐ Rubbed / Abraded
- ☐ Stepped On Sharp Object
- ☐ Strain
- ☐ Struck Against An Object
- ☐ Struck By An Object
- ☐ Other (specify)

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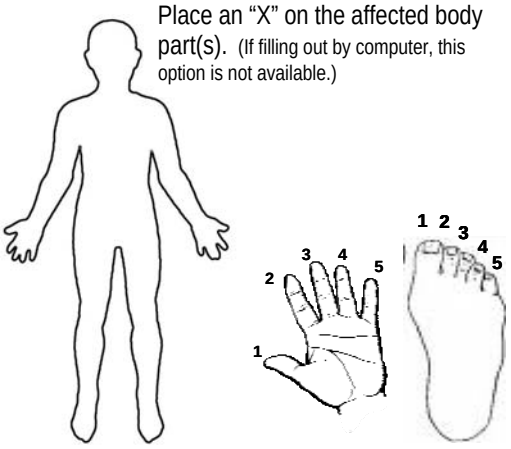
Body Part(s) Affected:

- ☐ Left ☐ Right
- ☐ Upper ☐ Middle ☐ Lower
- ☐ Top ☐ Bottom

- ☐ Ankle
- ☐ Arm
- ☐ Back
- ☐ Body (General)
- ☐ Chest
- ☐ Ear
- ☐ Elbow
- ☐ Eye(s)
- ☐ Face
- ☐ Finger(s) *specify # 1,2,3,4,5* _____
- ☐ Foot
- ☐ Forehead
- ☐ Hand
- ☐ Head
- ☐ Heart
- ☐ Jaw
- ☐ Knee
- ☐ Leg
- ☐ Nose
- ☐ Shoulder
- ☐ Toe(s) *specify # 1,2,3,4,5* _____
- ☐ Tooth / Teeth
- ☐ Trunk / Torso
- ☐ Wrist
- ☐ Other (specify): _____

Place an "X" on the affected body part(s). (If filling out by computer, this option is not available.)



Activity at time of incident:

- ☐ Bystander / Spectator
- ☐ Climbing
- ☐ Communications
- ☐ Cutting / Sawing / Drilling
- ☐ Digging
- ☐ Driving
- ☐ Engineering or Construction
- ☐ Fabricating
- ☐ Fire Fighting
- ☐ Food / Drink Consumption or Preparation
- ☐ Hammering
- ☐ Handling Material
- ☐ Horseplay
- ☐ Janitorial / Housekeeping
- ☐ Maintenance / Repair / Servicing
- ☐ Operating Manual / Hand Tools
- ☐ Operating Power Tools
- ☐ Pulling Wire
- ☐ Test / Study / Experiment
- ☐ Training
- ☐ Walking
- ☐ Wire Termination
- ☐ Other (explain):

Has individual received training specific to the activity? ☐ Yes ☐ No

If yes, when?

- ☐ 0 – 12 months
- ☐ 1 – 2 years
- ☐ 3 – 5 years
- ☐ More than 5 years
- ☐ Unknown

Is individual licensed to operate vehicle or equipment?

☐ Yes ☐ No ☐ N/A

*Required Protective Equipment:

- ☐ Face Shield
- ☐ F/R Clothing
- ☐ Ear Plugs
- ☐ Gloves – If yes, type of gloves? _____
- ☐ Goggles / Safety Glasses
- ☐ Hard Hat
- ☐ Harness & Lanyard
- ☐ Minimum Required Boots
- ☐ Protective Footwear
- ☐ Seat Belt
- ☐ Other (specify):

Was the required protective equipment available?
☐ Yes ☐ No ☐ N/A

Was the required protective equipment being used?
☐ Yes ☐ No ☐ N/A

Condition of the protective equipment:
☐ Good ☐ Fair ☐ Poor ☐ N/A

* Please retain any and <u>all</u> PPE that was involved in this incident!

Environmental Conditions:

- ☐ Clear / dry; visibility unlimited
- ☐ Bright, glare
- ☐ Dark, dim
- ☐ Fog, condensation, frost
- ☐ Mist, rain
- ☐ Sleet, hail
- ☐ Snow, ice
- ☐ Dust, fumes, gases, smoke, vapors
- ☐ Noise, bang, static
- ☐ Temperature _____ºF / humidity
- ☐ Storm, hurricane, tornado
- ☐ Wind gusts, turbulence
- ☐ Vibrate, shimmy, sway, shake
- ☐ Radiation, laser, sunlight
- ☐ Holes, rocky, rough, uneven
- ☐ Inclined, steep
- ☐ Slippery
- ☐ Air pressure
- ☐ Lightning, static electricity, ground
- ☐ Other (specify)

Attachments – check all that apply:

- ☐ Pictures (with explanations)
- ☐ Drawings, etc.
- ☐ Pre-Job Briefing Records (JHA's, etc.)
- ☐ Pre-Task Planning Cards
- ☐ Training Records
- ☐ Employee Statement
- ☐ Witness Statement
- ☐ Customer-required Forms
- ☐ Other (describe)

INCIDENT INVESTIGATION REPORT

Chronological sequence of events: 1)	2) .
3)	4)
5)	6)
7)	8)
9)	10)

Others Involved? ☐ Yes ☐ No If yes, list others:

Witnesses? ☐ Yes ☐ No If yes, list Witnesses:

Why was the mistake made/activity performed incorrectly? ☐ Effects of alcohol / drugs ☐ Fear / excitement ☐ Improper equipment design ☐ Improper supervision ☐ Inadequate facilities ☐ Inadequate training ☐ Inadequate written procedures ☐ Inattention to detail / unaware of surroundings ☐ Lack of rest / sleep ☐ Overconfidence in self or others abilities ☐ Poor attitude ☐ Other (specify)	If equipment is involved, list the equipment and indicate the condition of the equipment: ☐ New / Excellent Condition ☐ Good Condition ☐ Fair Condition ☐ Poor Condition If equipment was involved, was it properly sized for the task, adequate for the task, appropriate for the task, etc? ☐ Yes ☐ No Comments:

Incident Reported to:	Phone number:
Site Safety Person:	Phone number:

Additional Information:

INCIDENT INVESTIGATION REPORT

EMPLOYEE STATEMENT

Name of Injured / Involved:	Home Address:
Phone Number:	Job # Project Name:
Date of Incident:	Time of Incident: _____ ☐ AM ☐ PM

In your own words, from start to finish, describe what you did or observed. (What did you do, see, hear, feel, smell and taste?)
Use additional sheets of paper if necessary.

Statement:

Is there anything else that you think we should know, or anyone else you think we should speak to in order to perform our investigation?

Reported to:	Foreman:
Signature:	Date:

INCIDENT INVESTIGATION REPORT

WITNESS STATEMENT

Name of Witness:	Home Address:
Phone Number:	Job # Project Name:
Date of Incident:	Time of Incident: _____ ☐ AM ☐ PM

In your own words, from start to finish, describe what you did or observed. (What did you do, see, hear, feel, smell and taste?)
Use additional sheets of paper if necessary.

Statement:

Is there anything else that you think we should know, or anyone else you think we should speak to in order to perform our investigation?

Signature:	Date:

INCIDENT INVESTIGATION REPORT
CORRECTIVE ACTIONS

Immediate Action:	Responsible Party:	Date: Completion Date:
Long Term Action:	Responsible Party:	Date: Completion Date:
Lessons Learned:		
Corrective Action Implemented? ☐ Yes ☐ No	Corrective Action is Satisfactory? ☐ Yes ☐ No If no, what further action is needed?	
Is additional investigation necessary? ☐ Yes ☐ No	Initials: Date:	

In the event of SERIOUS INJURY, contact Project Manager IMMEDIATELY!

~~ Complete and Send Incident Report, Job Analysis, Photos and Attachments within 8 hours! ~~
Fax: _____ ~~ Email: _____
If fax or email is not available, _____ *and* Mail to: _____.
If Medical Attention is needed (and is not available on site) call _____.