Incident Report
Injury / Vehicle-Equipment-Property Damage / Near Miss / Other

This form is to be used to record "Injury, Vehicle, Equipment or Property Damage, Near Misses and any "Other" incidents which occur.

"X" All that Apply	Injury		Vehicle or Equipment Damage		Near Miss		Other (Please Specify)	

Where	Project Name:							
	Project Number:							
	Project Address:							
	Exact Location of the Incident:							
When	Date of Incident:							
	Time of Incident:				AM		PM	
What	Task Being Performed:							
	Proper PPE for the Task?	Yes		No		Why Not?		

Describe the Incident

Who	Name of Employee:		Title:	
	Contact Number:		Employer (If Contract):	
	Name of Employee:		Title:	
	Contact Number:		Employer (If Contract):	
	Name of Employee:		Title:	
	Contact Number:		Employer (If Contract):	

Injury							
Nature and Extent of Injury							
Injury Type:				**Affected Body Part:**			
"X" all that apply below.		**If "X"; provide an explanation below.**					
Recordable							
Lost Time							
Restricted Time							
Job Transfer							
Was the Injury a Result of:							
Unsafe Condition		**Unsafe Act**		**Unsafe Practice**			
Provide an Explanation:							
Vehicle / Equipment / Property Damage							
Nature and Extent of Vehicle / Equipment / Property Damage							
What was Damaged:							
Extent of Damage:							
Estimated Cost:							
Police Report?	**Yes**		**No**		**If "Yes"; attach to this report when available.**		
Near Miss							
Nature and Extent of the Near Miss							
What Happened?							
Result(s):							
Contributing Factors:							
Corrective Actions to Prevent Reoccurrence:							

Other								
Describe and Explain:								
Administrative								
Were the involved administered Drug and/or Alcohol Testing					**Yes**		**No**	
If "No"; why not?								
Results available?	**Yes**		**No**		**Pass**		**Fail**	
Were any Disciplinary Actions Taken as a Result of this Incident?					**Yes**		**No**	
If "Yes"; Describe:								

A Root Cause / Corrective Action (RCCA) may be required for this incident.
An RCCA is <u>mandatory</u> for all incidents resulting in a Recordable, Lost Time or Restricted Time Injury.

Printed Name of Person Completing this Report

Signature of Person Completing this Report

Date:	

EMPLOYEE REPORT OF INJURY

*****ALL injuries must be reported even if treatment is not required*****

I realize that if a report is to be filed with the workers' compensation adjustment company I have a duty to include in this report my description of the accident, including body part(s) affected.

Name:	Phone #	
Address:		
Date of Injury:	Time of Injury :	AM PM
Jobsite Name:	Jobsite #	
Supervisor's Name:	Contact #	
Where on the jobsite were you injured(specific)		
Describe in detail what happened:		
Body Part(s) Injured:		
The following people were present and might be a witness:		
Specify the machine, tool, substance or object that was directly involved with the injury:		

I feel I will need medical treatment at this time ……..	Yes	NO
I feel I do not need medical treatment at this time ……..	Yes	NO
I feel I will need medical treatment in the future ……..	Yes	NO

Employee Signature:	Date:
Printed name of Supervisor:	Date:
Due to my inability to write/read this report,_____read/translated it to me.	

Any person who knowingly and with intent to injure, defraud, or deceive any employer or employee, insurance company or self insured insurance program, files a statement or claim containing any false or misleading information, is guilty of a felony of the third degree.

GILCHRIST SAFETY SOLUTIONS, LLC.

WITNESS STATEMENT FORM

You have been listed as a possible witness of an accident/incident involving:

_____, on _____
(Employee Name) (Date)

at_____.
(Job Name / Location)

Please provide a statement of what you heard or saw concerning the accident/incident. Please provide any information you feel will give facts concerning the accident as well as other witnesses.

_____

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