WORKPLACE INCIDENT REPORT

This report records an incident that occurred on _____ in connection with the operations of _____ (the "Company"). It is an internal record, made to set down the facts while they are fresh and to help prevent a similar incident.

Type of incident (check one): [ ] injury or illness [ ] near miss (no one hurt, nothing damaged) [ ] property or equipment damage [ ] vehicle incident [ ] security or violence incident.

1. REPORT DETAILS

Report number: _____. Department or site: _____. Date of report: _____.

Prepared by: _____, job title: _____. Phone or email: _____.

The person preparing this report (check one): [ ] was involved in the incident [ ] saw it happen [ ] supervises the people or area involved [ ] learned about it afterwards from others.

2. INCIDENT SUMMARY

Date: _____. Time: _____. Exact location: _____. Reported to the Company on: _____.

Task under way at the time: _____.

[ ] No one was injured. [ ] No property was damaged. For a near miss, what could have happened: _____.

3. PEOPLE INVOLVED

1. Name: _____. Role: [ ] employee [ ] contractor or temp [ ] visitor or customer [ ] member of the public [ ] other. Injured: [ ] yes [ ] no.

2. Name: _____. Role: [ ] employee [ ] contractor or temp [ ] visitor or customer [ ] member of the public [ ] other. Injured: [ ] yes [ ] no.

3. Name: _____. Role: [ ] employee [ ] contractor or temp [ ] visitor or customer [ ] member of the public [ ] other. Injured: [ ] yes [ ] no.

4. DESCRIPTION OF THE INCIDENT

What happened, step by step:

_____

Equipment, tools or materials involved: _____.

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5. INJURY OR ILLNESS (COMPLETE ONLY IF SOMEONE WAS HURT)

Nature of the injury or illness and body part affected: _____.

First aid given, and by whom: _____.

Medical treatment (check one): [ ] first aid only [ ] offered and declined [ ] clinic or doctor's office [ ] emergency room, released [ ] admitted to a hospital as an in-patient [ ] the person died [ ] not known yet. Clinic, hospital or doctor: _____.

[ ] The injury involved an amputation or the loss of an eye. Work status now: [ ] regular duties [ ] restricted or light duty [ ] off work [ ] not known yet.

The Company keeps medical information in this report confidential, stores it apart from personnel files, and shares it only with people who need it to manage the incident, a claim or a legal requirement.

6. DAMAGE, VEHICLE AND POLICE DETAILS (IF THEY APPLY)

Property or equipment damaged, and how: _____. Estimated repair or replacement cost: $_____.

Vehicle (year, make, model, plate): _____. Owner: [ ] the Company [ ] an employee, used for work [ ] rental [ ] someone else. Driver: _____.

Other vehicles, drivers and insurance details: _____.

Security incident (check one): [ ] theft or burglary [ ] vandalism [ ] threat, intimidation or harassment [ ] physical assault or fight [ ] unauthorized entry or trespass [ ] other.

Police called: [ ] yes [ ] no. Police department and report number: _____.

7. WITNESSES

1. Name: _____. Phone or email: _____. Written statement: [ ] yes [ ] no.

2. Name: _____. Phone or email: _____. Written statement: [ ] yes [ ] no.

[ ] No witnesses were identified.

8. IMMEDIATE RESPONSE

Actions taken right away: _____.

Notified: [ ] a supervisor [ ] safety manager or coordinator [ ] Human Resources [ ] senior management [ ] emergency services (911) [ ] insurance carrier [ ] OSHA.

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9. CAUSES AND CORRECTIVE ACTIONS

Causes and contributing factors: _____.

[ ] The causes are still under investigation.

1. Action: _____. Responsible person: _____. Due date: _____.

2. Action: _____. Responsible person: _____. Due date: _____.

3. Action: _____. Responsible person: _____. Due date: _____.

10. ATTACHMENTS

[ ] Photographs of the scene are attached. Other attachments: _____.

11. REPORTER'S STATEMENT

I prepared this report. The information in it is true and complete to the best of my knowledge, and where it describes events I did not see myself, it relies on the people named in it.

Federal law prohibits discharging or discriminating against an employee for reporting a work-related injury or illness (29 C.F.R. § 1904.35(b)(1)(iv)), and the Company does not retaliate against anyone who reports an incident in good faith.

SIGNATURES

Reporter

Signature: _____ Date: _____

Printed Name: _____

Reviewing Supervisor (name and title)

Signature: _____ Date: _____

Printed Name: _____

SUPERVISOR REVIEW

I have reviewed this report, including the corrective actions and the people responsible for them. Comments: _____.

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