

AB&R Incident Report & Cause Analysis Investigation Form

Project Name: _____
Project Number: _____

Select the Appropriate Report

Incident Report <input type="checkbox"/>	Worker Injury <input type="checkbox"/>	First Aid <input type="checkbox"/>	Near Miss <input type="checkbox"/>	Equipment Property Damage <input type="checkbox"/>	PMI <i>(Public Motorist Incident)</i> <input type="checkbox"/>
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Fill out all blocks. Be as specific as possible. Include drawings, photos, and additional narrative as needed.

Building/Location
(Street #, City, State, Zip Code)

Supervisor Contact Information

Reporting Supervisor / Investigator Name:		Title:	
Directorate / Department:		Ext:	
Date of Incident:	Time of Incident:	Time of Report:	Date of Report:
	<input type="checkbox"/> A.M. <input type="checkbox"/> P.M.	<input type="checkbox"/> A.M. <input type="checkbox"/> P.M.	

Contractor Involved? Yes No **If Yes, please enter the contractor's information below:**

Contractor Name: (First & Last Name)

Contact Information:
(Company Name and Contact Information)

Injured Party / First Aid / Near Miss

<p>If NO INJURY, select the box below & skip this section</p> <p style="text-align: center;"><input type="checkbox"/></p>	Employee Name:	
	Employee Title:	
	Employee #	
	Forman:	
	Employee Contact Information	

Nature Of Injury/Illness:	Body Part Injured(s)
Strain/Sprain	Internal
Fracture	Burn/Scald
Laceration/Cut (Where)	Chemical Reaction
Bruising	Foreign Body
Scratch/Abrasion	Allergic Reaction
Amputation (Where)	Heat Related Illness
Dislocation	Other (Specify)
Concussion	

Police Information, EMS, Towing Company, and Witness and/or witness statement(s)

Information Needed	Name
Name of police working the scene and phone number:	

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Police Case Number to the Incident:					
EMS Company Name and phone number:					
Tow Truck Company name and phone number:					
Witnesses (name and contact information):					
License Plate numbers of all involved in the incident:	1. 2. 3.				
Witness statement attached.	<input type="checkbox"/> Yes <input type="checkbox"/> No				
Property / Equipment Damage					
List property / material damaged (use control numbers if available):					
Property / Material	Control #	Nature of Damage			
Object / Substance Inflicting Damage	Approximate Cost	Rental			
			Yes		No
			Yes		No
			Yes		No
			Yes		No

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The Incident (Use Additional Paper as Needed, Reference Below and Attach)

Describe what happened. (Investigate scene of incident or conditions. Describe who was involved, when and where the incident happened, what happened, and how.)

Large empty rectangular box for incident description.

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Why did it happen? (Root Cause Analysis)

What was the root cause of the incident, i.e., actually caused the illness, injury, or incident?

Place an X next to what applies.

Unsafe Acts		Unsafe Conditions		Management System Deficiencies	
<input type="checkbox"/>	Improper Work Technique/Procedure	<input type="checkbox"/>	Poor Workstation Design or Layout	<input type="checkbox"/>	Lack of Written Procedures or Safety Rules
<input type="checkbox"/>	Improper PPE, Not Used or Used Incorrectly	<input type="checkbox"/>	Fire or Explosion Hazard	<input type="checkbox"/>	Safety Rules Not Enforced
<input type="checkbox"/>	Safety Rule Violation	<input type="checkbox"/>	Congested Work Area	<input type="checkbox"/>	Hazards Not Identified
<input type="checkbox"/>	Operating Without Authorization	<input type="checkbox"/>	Hazardous Substances	<input type="checkbox"/>	PPE Unavailable
<input type="checkbox"/>	Failure to Warn or Secure	<input type="checkbox"/>	Inadequate Ventilation	<input type="checkbox"/>	Insufficient Worker Training
<input type="checkbox"/>	Operating at Improper Speeds	<input type="checkbox"/>	Improper Material Storage	<input type="checkbox"/>	Insufficient Supervisor Training
<input type="checkbox"/>	By-Passing Safety Devices	<input type="checkbox"/>	Improper Tool or Equipment	<input type="checkbox"/>	Improper Maintenance
<input type="checkbox"/>	Guards Not Used	<input type="checkbox"/>	Insufficient Job Knowledge	<input type="checkbox"/>	Inadequate Supervision
<input type="checkbox"/>	Improper Loading or Placement	<input type="checkbox"/>	Slippery Conditions	<input type="checkbox"/>	Insufficient Job Planning
<input type="checkbox"/>	Improper Lifting	<input type="checkbox"/>	Poor Housekeeping	<input type="checkbox"/>	Inadequate Hiring Practices
<input type="checkbox"/>	Servicing or Adjusting Machinery in Motion	<input type="checkbox"/>	Excessive Noise	<input type="checkbox"/>	Poor Process Design
<input type="checkbox"/>	Horseplay	<input type="checkbox"/>	Inadequate Guarding of Hazards	<input type="checkbox"/>	Inadequate Workplace Inspections
<input type="checkbox"/>	Drug or Alcohol Use	<input type="checkbox"/>	Defective Tools/Equipment	<input type="checkbox"/>	Inadequate Equipment
<input type="checkbox"/>	Unsafe Act(s) of Others	<input type="checkbox"/>	Insufficient Lighting	<input type="checkbox"/>	Unsafe Design or Construction
<input type="checkbox"/>	Unnecessary Haste	<input type="checkbox"/>	Inadequate Fall Protection	<input type="checkbox"/>	Unrealistic Scheduling
<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>	
<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>	

List immediate actions taken and results

What should be done to prevent a recurrence? (Be specific as to what would prevent the injury, incident or damage from occurring again)

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Corrective Actions Tracking (All Blocks Must be Filled in and Information Verifiable)

List action(s) that have or will be taken to prevent a recurrence.	Assigned To Whom	Scheduled Completion Date	Actual Completion Date	Follow-up Date

Job Hazard Analysis Review

Is there a JHA that applies to the task being performed when the injury or incident occurred? <i>If yes, review the JHA, answer the following questions, and attach a copy to this report.</i>	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Were the job hazards identified to the crew working/employee(s)? If not, please explain.	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Were identified safety controls adequate and implemented? If so, by who? If not, please explain.	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Were specific safety instructions implemented or given to the employee(s)/crew? If not, please explain.	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No

Investigation Team (Print And Sign)

Signature	Name	Title

cc: Attachments: JSA required for all injuries. Pictures, Etc.

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Use this page as an additional page to describe what happened. (*Supplement to Page 3*)

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