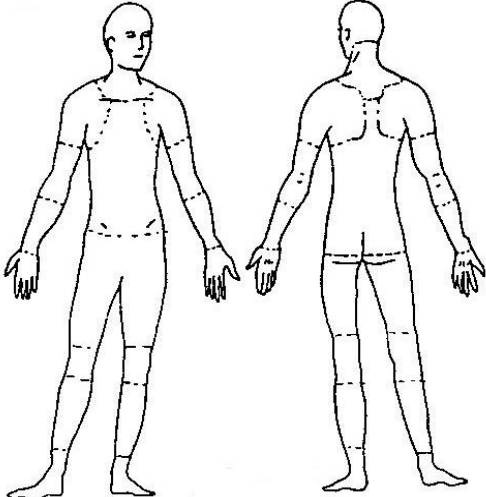




**Instructions:** Complete this form as soon as possible after an incident that results in an injury or illness.

<b>This is report of:</b> <input type="checkbox"/> Fatal <input type="checkbox"/> Lost time <input type="checkbox"/> Medical aid <input type="checkbox"/> First aid only <input type="checkbox"/> Incident with injury/illness				
If worker attended medical aid, who transported them?				
Incident date	<b>Report by:</b>	<input type="checkbox"/> Supervisor	<input type="checkbox"/> Site Safety—OFA	<input type="checkbox"/> Corporate Safety Manager

**Step 1: INJURED EMPLOYEE (COMPLETE THIS PART FOR EACH INJURED EMPLOYEE)**

Worker name (if injured)	Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female	Birth date
Company involved	Job title at time of incident	
Part of the body affected: (shade all that apply)  	Nature of injury (most serious one) <input type="checkbox"/> Abrasion, scrape(s) <input type="checkbox"/> Amputation <input type="checkbox"/> Broken bone(s) <input type="checkbox"/> Bruise(s) <input type="checkbox"/> Burn (heat) <input type="checkbox"/> Burn (chemical) <input type="checkbox"/> Crushing injury <input type="checkbox"/> Cut(s), laceration, puncture <input type="checkbox"/> Facial injury <input type="checkbox"/> Head injury <input type="checkbox"/> Hernia <input type="checkbox"/> Illness <input type="checkbox"/> Sprain, strain  <input type="checkbox"/> Damage to a body system: _____ (i.e.: nervous system, respiratory, or circulatory systems)  <input type="checkbox"/> Other: _____	This worker works on site: <input type="checkbox"/> Regular full time <input type="checkbox"/> Regular part time <input type="checkbox"/> Temporary <input type="checkbox"/> As work dictates  Month/yrs. With present employer:  Duration on this project:

**Step 2: DESCRIBE THE INCIDENT**

Exact location of the incident		Exact time:		
What part of the workday?		<input type="checkbox"/> Entering or leaving project <input type="checkbox"/> Doing normal work activities <input type="checkbox"/> During lunch period <input type="checkbox"/> During break <input type="checkbox"/> Working overtime <input type="checkbox"/> Other		
What personal protective equipment was being used (if any)?				
Were there any witnesses:		<input type="checkbox"/> Yes <input type="checkbox"/> No <b>Important:</b> Witnesses are persons that actually saw the actual incident occur or relevant events that led up to the actual incident.		
Witness name:		Address		
Witness name:		Address		
Witness name:		Address		
Number of attachments:	Written statements:	Photographs:	Maps:	Drawings:





Were written work procedures available?  Yes  No

Were they being followed?  Yes  No

If not explain why.


**Step 4: INCIDENT CAUSES (check all that apply)**

<input type="checkbox"/> Combative person(s)	<input type="checkbox"/> Improper guarding	<input type="checkbox"/> Inadequate lighting	<input type="checkbox"/> Hazardous storage
<input type="checkbox"/> Defective equipment	<input type="checkbox"/> Inadequate ventilation	<input type="checkbox"/> Contact w/ irritants	<input type="checkbox"/> Hazardous weather
<input type="checkbox"/> Distraction by others	<input type="checkbox"/> Inadequate warning	<input type="checkbox"/> Unsafe surface	<input type="checkbox"/> Faulty safety equipment
<input type="checkbox"/> Faulty / poor design	<input type="checkbox"/> PPE not used	<input type="checkbox"/> Contact w/ toxin	<input type="checkbox"/> Unsecured equip.
<input type="checkbox"/> Hazardous procedures	<input type="checkbox"/> Insect/animal attack	<input type="checkbox"/> Poor housekeeping	<input type="checkbox"/> Unsafe procedures
<input type="checkbox"/> Unauthorized use	<input type="checkbox"/> Wrong tool used	<input type="checkbox"/> Inhaled toxin	<input type="checkbox"/> Unsafe speed
<input type="checkbox"/> Insufficient training	<input type="checkbox"/> Improper apparel	<input type="checkbox"/> Unsafe position	<input type="checkbox"/> Unsafe posture
<input type="checkbox"/> Worker error	<input type="checkbox"/> Failure to observe policies, rules or regulations		

Investigation reveals incident was beyond employee control

Other cause(s)


**Step 5: CONTRIBUTING FACTORS**

What were contributing factors to this incident






INDICATE  
DIRECTION

