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INCIDENT REPORT

PERSON INVOLVED	JOB TITLE / DEPARTMENT	EMPLOYEE / VISITOR / CONTRACTOR	REPORT NO.

Date _____ Time _____ Reported to _____

Location _____ Reported at _____ Supervisor _____

TYPE OF INCIDENT

- ❑ Injury
- ❑ Near miss
- ❑ Vehicle
- ❑ Security / violence
- ❑ Illness
- ❑ Property damage
- ❑ Fire / spill
- ❑ Other

DESCRIPTION: WHAT WAS THE PERSON DOING, WHAT HAPPENED, IN ORDER (FACTS ONLY)

EQUIPMENT, MATERIALS OR VEHICLES INVOLVED

Witnesses

Name	Phone / department	Statement attached
		❑
		❑
		❑

IMMEDIATE CAUSE (WHAT DIRECTLY LED TO IT)

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INCIDENT REPORT: FOLLOW-UP

Injury / illness (nature) _____ Part of body _____

First aid given by _____ Medical treatment (where, who) _____

Time off work (days) _____ Restricted duty (days) _____

REPORTING CHECKS

- ❑ OSHA recordable (beyond first aid, days off, restricted work)
- ❑ Entered on OSHA 300 log
- ❑ Severe: report to OSHA (fatality 8 h; hospital, amputation, eye 24 h)
- ❑ Workers' comp claim / insurer notified
- ❑ Police report (vehicle, theft, violence)
- ❑ Property owner / landlord told

ACTIONS ALREADY TAKEN (AREA MADE SAFE, EQUIPMENT TAGGED OUT)

Corrective actions to prevent it happening again

Action	Owner	Due	Done
			❑
			❑
			❑
			❑

Person involved _____ Supervisor _____ Date _____

Safety / HR reviewed _____ Date closed _____