



## First Report of Injury/Accident/Incident/Near-Miss

Employee Name: \_\_\_\_\_ Job Title: \_\_\_\_\_

Date & time of injury, accident, incident or near-miss Date: \_\_\_\_\_ Time: \_\_\_\_\_  a.m.  p.m.

Jobsite Name \_\_\_\_\_ Jobsite Address: \_\_\_\_\_

Jobsite Foreman: \_\_\_\_\_

Time employee began work on date of incident \_\_\_\_\_  a.m.  p.m.

**(If more room is needed for any questions below, please use sheet #2 to explain further in detail)**

Names of crew (and others on jobsite) that witnessed or were involved in the injury, accident or incident: \_\_\_\_\_

What job was being performed at the time of injury, accident or incident? (Describe in detail what objects, circumstances, or people caused the incident or contributed to the incident.)

What was the injury, accident or incident? (Detail and identify which hand, right or left, which finger, etc.)

What tools, equipment, machines, objects, or substances were involved?

Has similar injury, accident or incident happened before?  Yes (if yes, describe)  No

Due to unsafe conditions, should employee(s) be removed from jobsite?  Yes  No

What measures should be taken to avoid a reoccurrence?

Have the details of incident been discussed with the shop?  Yes  No

Who was notified: \_\_\_\_\_ Date: \_\_\_\_\_ Time: \_\_\_\_\_  a.m.  p.m.

### **INJURY INFORMATION**

Check here if NO medical attention was required.

Name of Treating Physician/Clinic: \_\_\_\_\_

Time Injured: \_\_\_\_\_  a.m.  p.m. Left Jobsite:  Yes  No

Transported by: \_\_\_\_\_

Give any other information you think is important to this claim.

Form information completed by: \_\_\_\_\_ Date completed: \_\_\_\_\_

All claims are to be reported to the office as soon as possible. This form is to be filled out by each person involved and returned to the office within 24 hours. Please call the office if you have a question.

