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|  | | | **Accident/Near Miss Report**  This report must be returned to the Safety Department within 24 hours of the incident. | | | | | | | | | | | | | | | | | | | |  |
| First Report of ACcident/Near-Miss | | | | | | | | | | | | | | | | | | | | | |  | | |
| **Project Data**  **(Must be completed in full)** | **Date of Incident:** | | | | | | | **Time: AM** or **PM** | | | | | | | | Day of Week | | | | | | | | |
| **Date of Report:** | | | | | | | | | | | | | | | **Weather:** | | | | | | | | |
| **Project Manager:** | | | | | | | | | | | | | | | **Project No.:** | | | | | | | | |
| **Foreman: Lead Man:** | | | | | | | | | | | | | | | **Project Name:** | | | | | | | | |
| **Exact Location of Incident:**  **Street Address \_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **City/State/Zip\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | | | | | | | | | | | | | **Drug Screen (s) Administered: Y or N**  **If Yes, List Employees:** | | | | | | | | | | |
| **Crew: NA** | | | | | | | | **Are There Any Witnesses? Y or N** | | | | | | | | | | | See Page 5 for Witness Instructions | | | | |
| **Type of Incident:** (circle) | | | WC | **GL** | | **Auto** | | | **Equip** | | | **Theft/Vandalism** | | | | Property | | | | Near-Miss | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | |
| Personal Injury – WC  **(To be completed for all employee injuries)** | **Injured Employee Name:** | | | | | | | | | | | | | | | | | Employee ID #: | | | | | | |
| **Employee Home**  **Address:** | **Street:** | | | | | | | | | | | | | | | **Date of Birth:** | | | | | | | |
| **City/State/Zip:** | | | | | | | | | | | | | | | **Phone:** | | | | | | | |
| **Occupation/Job Title:** | | | | | | | | | | **Years Experience: \_\_\_\_\_\_\_** | | | | | | **Date of Hire:** | | | | | | | |
| **Time Employee Started Work: AM** or **PM** | | | | | | | | | | | **Employment Status: (circle) FT PT TEMP SEASONAL** | | | | | | | | | | | | |
| **Onsite First Aid Given: Y or N** | | | | | **If Yes, by Whom & What Given:** | | | | | | | | | | | | | | | | | | |
| **Offsite Medical Treatment: Y or N** | | | | | **If Yes, Treating Facility: (Name, City, State)** | | | | | | | | | | | | | | | | | | |
| **Date Treatment Given:** | | | | | **List PPE worn at the time of incident:** | | | | | | | | | | | | | | | | | | |
| **Shade the Specific Body Part (s) Injured:** | | | | | | | | | | | | | | **Incident tracking**  **(See pg. 6 for code #’s)** | | | | | | | | | |
|  | | | | | | | | | | | | | | **Body Part:** | | | | **Accident Type #** | | | | | |
|  | | | | **Cause Code #** | | | | | |
| **Detailed Description of Injury:** | | | | | | | | | |
| |  |  | | --- | --- | |  | | | **Safety Dept. Only Incident Designation (To be completed by office):** | | | * **First Aid Only** * **Non Recordable – *Medical Treatment*** * **Recordable – *Medical Treatment*** | * **Restricted Work** * **Recordable - Lost Time** * **Claim Denied** | | | | | | | | | | | | | | | | | | | | | | | | | |

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| General Liability  **(To be completed for bodily ll injury and / or property damage to others as a result of our work)** | | **Property Owner Name:** | | | | | **Phone:** | |
| **Property Owner Address:** | **Street:** | | | | Cell: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Home: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **Office \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | |
| **City/State/Zip:** | | | |
| |  | | --- | | **Insurance Information:**  **Company \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **Policy #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **Phone #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |   **Detailed Description of Damages: (draw diagram – next page)** Year,/Make, Model of Vehicle: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Estimated Damage: $\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **Pictures Taken: Y or N** | | | | | | |
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| **Auto & Equipment**  **(To be completed for all automobile and equipment accidents)** | **Operator Name:** | | | | **Equipment / Vehicle Number:** | | | **Cause Code (pg. 6)** |
| **Vehicle / Unit: (Make, Model, Type):** | | | | **Rental: Y or N** | | | **Rented From** |
| **Rental Company Phone:** | | | | | **Estimated Damage:** | | |
| **Did Operator/Driver obey all applicable safety rules or D.O.T. Motor Vehicle Laws?**  **Y or N - If NO, list exceptions:** | | | | | | | |
| **Did Authorities Respond (fire, police, ambulance, etc)? Y or N** | | | **Responding Authority:** | | | | |
| **Contact Person Name:** | | | | |
| **Phone Number: :** | | | | |
| **Was there Other Vehicle or Property Damage: Y or N - If yes, please specify:** | | | **Report / Incident Number:** | | | | |
|  | | | **Owners Name (if different then Driver)::** | | | | |
| **License No. & State:** | | | | |
|  | | | | |
| **For Vehicle Damage, Shade the Specific areas damaged:**  2 | | | | | | | |

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| **Description of Incident** | | To be completed for all incidents | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Describe in detail the circumstances of the incident. Give a chronological sequence of events. If materials, equipment and/or vehicles were involved, start before they were brought to the incident scene and describe the who, what, where when, and how the incident happened in your words below (specifically detail who, what, where, when, how, and why you believe the incident happened):** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **To be completed for** all **incidents** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **(Show position and any relative distances of employee(s), vehicle(s), equipment, pedestrians, property, etc., and indicate an arrow of direction for each if travel or moving equipment was involved):** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Diagram of Incident** |  | |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | | |
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| **Employee / WITNESS Statement Form** | | | | |
|  | | | | |
| **Witness Name:**  (Please Print) | | **Work Ph:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Home Ph:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **Cell Ph:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | | |
| **Witness Address:** | | | | |
| **Date and Time of incident: am / pm** | | | **List other Witnesses:** | |
| **Supervisor Notified on Date and Time: am / pm** | | |
|  | | | | |
| **This is what happened (include who, what, where, when, how and why):** | | | | |
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| **Do you recall anything unusual or unexpected that happened? Yes or No If Yes Explain:** | | | | |
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|  | | | | |
| **Are there work conditions that contributed to this injury? Yes or No If Yes Explain** | | | | |
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|  | | | | |
| **How would you prevent this incident from happening in the future?** | | | | |
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| **Please use and attach additional pages if necessary** | **Witness Signature:** | | | **Date:** |

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| **Participants of the Incident Analysis** | | Management Review | |
| **Name/Title or Trade** | **Date** | **Name** | **Date** |
|  |  |  |  |
|  |  | Foreman: |  |
|  |  |  |  |
|  |  | Project Manager: |  |
|  |  |  |  |
|  |  | Safety Director: |  |
|  |  |  |  |
|  |  | Other: |  |
| **Employee**  **Signature:**  **(print)** |  |  |  |
|  |  |
| **Employee**  **Signature:** |  |  |  |
|  |  |

**ACCIDENT TYPE**

4

**1 Falls On Same Level**: Slips, trips, or falls on foot level surfaces such as the ground, floors, stairs, work platforms, or rebar. Includes slips on mud, liquids, ice and other slippery surfaces and trips over obstacles such as tools, cords, rocky or uneven surfaces.

**2 Falls From Elevations:** Falls to a lower level from elevated surfaces. Includes falls from structural steel, scaffolds, work platforms, form work, equipment, etc.

**3 Falls From Ladders:** Falls from portable or fixed ladders including stepladders.

**4 Falls into Opening:** Falls into floor holes, openings in the ground (i.e., caisson holes, unguarded ditch/excavation, etc.)

**5 Material Handling – Manual:** Injuries from manually moving tools, equipment, or material. This includes over exertion due to lifting or carrying material manually and usually results in sprains/strains of the back and other body parts.

**6 Caught In/Under/Between:** Injuries caused by power tools or eqiupment and resulting in crushing or pinching of fingers and/or other body parts.

**7 Struck By/Against Object:** Injuries caused by employees being struck by flying or moving objects, or injuries caused by empolyees bumping into/against stationary objects.

**8 Struck By Flying Object-Eye:** Eye injuries only caused by grinding, chipping or other operations. Includes windblown dust and foreign bodies entering the eye.

**9 Occupational Illness** – includes the following:

a. Skin diseases/disorders – poision ivy, heat rash, contact dermatitis, etc.

1. Dust disease of lungs – silicosis, asbestosis, etc.
2. Poisoning due to toxic materials – lead or other metal poisoning and poisoning by carbon monoxide or other gases
3. Illness due to physical agents – sunstorke, heat exhaustion, frostbite, or other illnesses caused by temperature extremes or environmental conditions
4. Disorders caused by repeated trauma – carpal tunnel syndrome, noise-induced hearing loss.

**10 Electrical Contact:** Injuries resulting in electrical shock caused by flow of electric current through the body. Includes shock from power tools, electrical cords, and contact with overhead power lines.

**11 Burns:** Injuries resulting in thermal (heat) or chemical burns. Includes burns caused by welding/cutting operations, or use of chemicals.

**12 Miscellaneous**: Avoid using this category. Only mark this category if the injury or illness doesn’t fit into another general accident type.

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| **CAUSE CODE** |  | **PART OF BODY** |
|  |  |  |
| 1.Improper handing of material | 1. | Ankle |
| 2. Improper lifting | 2. | Arm |
| 3. Improper use of tools/equipment | 3. | Back |
| 4. Making safety devices inoperative | 4. | Chest |
| 5. Failure to use PPE | 5. | Elbow |
| 6. Taking unsafe position | 6. | Eye |
| 7. Clean, adjust, etc. of moving equipment | 7. | Face |
| 8. Horseplay, distracting, fighting | 8. | Foot/Toe |
| 9. Improper/Inadequate guarding | 9. | Groin |
| 10. Defective equipment/tools | 10. | Hand/Finger |
| 11. Improper/defective walk area | 11. | Head |
| 12. Slippery/rough surface | 12. | Knee |
| 13. Poor housekeeping | 13. | Leg |
| 14. Improperly pile material | 14. | Neck |
| 15. Windblown dust | 15. | Shoulder |
| 16. Congested area | 16. | Wrist |
| 17. Poor working conditions |  |  |
| 18. Miscellaneous |  |  |

5