



CONSTRUCTION INDUSTRY INCIDENT AND INJURY REPORT

*The Workers Compensation Act Requires Notice of
Injury to Employee(s) Within 5 Business Days*
Have completed reports at the Safety Department within 24 hours.

DATE OF ACCIDENT: ___/___/___ TIME: _____AM/PM DATE REPORTED: ___/___/___ TIME: _____AM/PM

1. DID THE INCIDENT RESULT IN PERSONAL INJURY OR HOSPITALIZATION? <input type="checkbox"/> YES <input type="checkbox"/> NO TO WHOM? _____	2. DID THE INCIDENT INVOLVE PROPERTY OR EQUIPMENT DAMAGE? <input type="checkbox"/> YES <input type="checkbox"/> NO TO WHAT? _____
3. LOCATION _____	4. EQUIPMENT DAMAGE _____
5. PART OF BODY INJURED _____	6. IMMEDIATE SUPERVISOR _____
7. NATURE OF INJURY _____ _____	
8. WHAT HAPPENED TO CAUSE THE INJURY AND/OR DAMAGE? (SHOW DRAWINGS OR PHOTOGRAPHS--USE REVERSE FOR ADDITIONAL DETAILS) _____ _____	
9. RECOMMENDATIONS TO PREVENT RECURRENCE OF A SIMILAR INCIDENT _____ _____	
10. CORRECTIVE ACTION TAKEN AT WORKSITE _____ _____	
11. WHAT DEFECTIVE OR UNSAFE CONDITION(S) OF TOOLS, EQUIPMENT, MACHINERY, WORK AREA CONTRIBUTED TO THE ACCIDENT _____ _____	
12. WAS FIRST AID RENDERED? <input type="checkbox"/> YES <input type="checkbox"/> NO BY WHOM? _____ IF OUTSIDE EMERGENCY ASSISTANCE WAS REQUIRED, PROVIDE DETAILS _____ _____	
13. DOCTOR'S NAME _____	14. MEDICAL FACILITY _____
15. SEVERITY OF INJURY <input type="checkbox"/> MINOR-NO TREATMENT <input type="checkbox"/> FIRST AID ONLY <input type="checkbox"/> MEDICAL AID <input type="checkbox"/> LOST TIME <input type="checkbox"/> FATAL	
16. PROBABILITY OF RECURRENCE <input type="checkbox"/> FREQUENT <input type="checkbox"/> OCCASIONAL <input type="checkbox"/> RARE	