Jacobson & Greiner

Group of Companies

Incident Report

Company: ____________________________ Date of Report: _____/_____/_________
Last Name: ___________________________ First Name: _________________________________
Address: ________________________City/Town: ______________________ Province: _______
Postal Code: ___________ Phone # ______________________ Date of Birth: ___/____/_____
Date of Hire: _____/_____/_____ Occupation/Experience: _____________________________
Date of Incident: ___/_____/_______ Hour of Incident: _________ AM PM
Reported to: ____________________________ Date: ___/_____/______Hour: _____ AM PM
Project Name: ____________________________ Loc.of Proj.: City: ______________Prov: ____
Superintendent: _________________________Foreman: _______________________________

Was there any Injury? YES NO
Did the injured worker return to work that day or for the next scheduled shift following the injury? YES NO
Name and Address of Doctor/Hospital: ____

Part of Body:	**Nature of Injury:**	**Severity:**	**Treatment:**
○ Head	○ Abrasion	○ First Aid	○ On Site (First Aid)
○ Neck	○ Amputation	○ Medical Aid	○ Sent to Doctor (M.A.)
○ Back	○ Laceration	○ Lost Time	○ Sent to Hospital (M.A./Lost Time)
○ Abdomen	○ Puncture		○ Ambulance
○ Arm	○ Bruise		
○ Knee	○ Foreign Body		
○ Hip	○ Fracture		
○ Foot	○ Sprain		
○ Hand	○ Burn		
○ Wrist	○ Flash Burn		
○ Shoulder	○ Other: (Specify)		
○ Finger			
○ Leg			
○ Ankle			
○ Eye			
○ Other: (Specify)		Specify Part of Body Location ○ Right ○ Left ○ Upper ○ Lower	

<u>IF THERE IS INJURY</u>. ANSWER ALL THESE QUESTIONS. Explain "YES" answers below <u>OR</u> attach a letter if necessary.

1. Was anyone not in your employ totally or partially responsible for the accident?
   NO YES
2. Do you have any reason to doubt the history of the injury?
   NO YES
3. At the time of the injury, was the employee doing work other than for the purpose of the employer's business? **NO YES**
4. To your knowledge, has the employee had a previous similar disability?
   NO YES
5. Do you have any information that the employee could have returned to work earlier?
   NO YES

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Any Witnesses to this accident? **YES NO**
Witness Name: ____________________ Company Employed by: ____________________
Address: ______________________City/Town: ______________________________
Province: ______ Postal Code: __________ Phone # ______________________________
Witness Name: ____________________ Company Employed by: ____________________
Address: ______________________City/Town: ______________________________
Province: ______ Postal Code: __________ Phone # ______________________________
Witness Name: ____________________ Company Employed by: ____________________
Address: ______________________City/Town: ______________________________
Province: ______ Postal Code: __________ Phone # ______________________________

PLEASE ATTATCH WITNESS STATEMENTS

Equipment/Tools Involved:

UNIT # ________________ UNIT #________________ UNIT #_________________
Type: _________________ Type: _________________ Type: __________________
Est. Cost: $_____________ Est. Cost: $____________ Est. Cost: $______________

Describe the Incident: ____

What Happened ~ Describing the Incident

Activity at the Time:	Type:
○ Operating Machine ○ Hand Tool (Power) ○ Hand Tool (Manual) ○ Material Handling ○ Driving a Vehicle ○ Walking, Running or Climbing ○ Performing Maintenance ○ Lifting ○ Other(specify):	○ Fall (elevated) ○ Fall (same level) ○ Struck (by) ○ Struck (against) ○ Electrical Shock ○ Other (specify): ○ Slip/Twist ○ Exposure ○ Overexertion ○ Caught/Pinned

Why Did it Happen ~ Direct and Indirect Causes

- ○ Body Position
- ○ Housekeeping
- ○ Improper Guards
- ○ Defective Tools
- ○ Inadequate Help
- ○ Horseplay
- ○ Personal Protective Equipment
- ○ Improper Ventilation
- ○ Improper Illumination
- ○ Lack of Knowledge
- ○ Weather
- ○ Building Conditions
- ○ Failure to Secure
- ○ Failure to Observe
- ○ Disregard of Instruction
- ○ Ability/Judgement/Attention
- ○ Traffic

OTHER: (Please Specify):

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Corrective Action

Recommended: ____

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Taken:____

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What instruction, warning, training, or caution was given prior to the incident? ___________

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Diagram of Incident

ACCIDENT/INCIDENT MANAGEMENT FOLLOW-UP

Date: ______________________________

Present: ____

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Cause:____

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Root Cause: ____

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Recommendations Made:

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Action(s) to be Taken:	Date to be completed:	To be Completed by:

All actions completed:

Signature: ________________________________ Date: ______________________________

Signature: ________________________________ Date: ______________________________

Site Foreman Name: (print) ____

Signature: ____

Worker Safety Rep: (print) ____

Signature: ____

WH&S Advisor: (Print) ____

Signature: ____

Senior Management: (print) ____

Signature: ____