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

IF THERE IS INJURY. ANSWER ALL THESE QUESTIONS. Explain "YES" answers below OR 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

Describe:

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

OTHER: (Please Specify):

Employee's Recommendation:

Where their special instruction, warning, training, or caution given prior to the incident?

Diagram of Incident

ACCIDENT/INCIDENT MANAGEMENT FOLLOW-UP

Date: _____

Present:

Cause:

Root Cause:

Recommendations made:

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: _____