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| **Incident Type:** | | |  | | | Work Comp | |  | | General Liab. | | | | | | | Auto Liab. | | | | Prop/Equip/Asset | | | | | | | |  | | |  | |  | | | Other |
| Today’s Date: Pick Date | | | | | | | | JV: | | | | | | OCIP: | | | | | | CCIP: | | | | | | Other: | | | | | | | | | | | |
| **INCIDENT INFORMATION** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Job #: |  | | | | | | | | | |  | |  | | | | | | Foreman/Supervisor: | | | | | | | | |  | | | | | | | | | |
| Project Name: | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Date of Loss: | | | Pick Date | | | | Time: | | | | | | | | AM  PM | | | | | | | | Date Reported: | | | | | | | | Pick Date: | | | | | | |
| Location of Incident: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Street: | | | | | | | | | | | | | | | | | | City: | | | | | | | | | County: | | | | | | | | State: | | |
| If Applicable complete the following about the employee involved in the Incident: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Last Name: | | | | | | | | | | | | | | | | | | Home Phone: | | | | | | | | | | | | | | | | | | | |
| First Name: | | | | | | | | | | | | | | | | | | Work Phone: | | | | | | | | | | | | | | | | | | | |
| Date of Birth: | | | | | | | | | | | | | | | | | | Cell Phone: | | | | | | | | | | | | | | | | | | | |
| Employee #: | | | | | | | | | | | | | | | | | | Job Title: | | | | | | | | | | | | | | | | | | | |
| Driver’s License #: | | | | | | | | | | | | | | | | | | Shift Start Time: | | | | | | | | | | | | | | | | | | | |
| Incident at Job Site?  Yes  No | | | | | | | | | | | | | | | | | | Shift End Time: | | | | | | | | | | | | | | | | | | | |
| Occurred on Jobsite?  Yes  No | | | | | | | | | | | | | | | | | | Date Last Worked: Pick Date: | | | | | | | | | | | | | | | | | | | |
| Drug/Alcohol Testing:  Yes  No | | | | | | | | | | | | | | | | | | If Not Tested, Why? | | | | | | | | | | | | | | | | | | | |
| Date Test Sent: Pick Date | | | | | | | | | Time Test Sent: | | | | | | | | | | | | | | | | Location Test Sent: | | | | | | | | | | | | |
| Employee Activity at time of incident: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Body Part (100): Choose fom List | | | | | | | | | | | | | | | | Body Side (200): Choose from List | | | | | | | | | | | | | | | | | | | | | |
| Nature of Injury (300): Choose from List | | | | | | | | | | | | | | | | Cause of Injury (400): Choose from List | | | | | | | | | | | | | | | | | | | | | |
| Injury Source (500): Choose from List | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **MEDICAL TREATMENT DETAILS** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Treatment Sought:  Yes  No | | | | | | | | | Initial Treatment: Pick Date: | | | | | | | | | | | | | | | Admitted Overnight to Hospital: | | | | | | | | | Yes  No  Unknown | | | | |
| Treated in Emergency Room:  Yes  No  Unknown | | | | | | | | | | | | | | | | | | | | | | | |
| Name, Address,& Phone Number of Clinic/Hospital: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Treated by: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | Date: Pick Date: | | | | | | | |
| Fatality | | Lost Time | | | Restricted / Modified Duty | | | | | | | Recordable Medical Treatment | | | | | | | | | | Non-Recordable Medical Treatment ☐ | | | | | | | | First Aid Only / FYI | | | | | | Non- Work Related | |
| **INCIDENT DESCRIPTION** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Describe how the incident occurred: include full name (first and last) of those involved (relation & job title) and job activity at the time of the incident in chronological order: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| **IMPORTANT:** Full name all Witnesses, w/ Addresses and Phone Numbers: | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | |
| **Note: Pictures are essential to a full investigation if possible include general pictures of the Project/ Area along with specific pictures of specific areas of interest/damage.** | | | | | | | | | | | | | | | | | | | | |
| **CLAIMANT/THIRD PARTY INFORMATION** | | | | | | | | | | | | | | | | | | | | |
| Claimant Name: | | | | | | | | Phone#: | | | | | | Bus./Cell #: | | | | | | |
| Claimant Address: | | | | | | | | | | | | | | | | | | | | |
| Owner of Damaged Property (if different): | | | | | | | | | | | | | | | | | | | | |
| Address of Owner (if necessary): | | | | | | | | | | | | | | | | | | | | Phone #: |
| Describe Claimant’s Property (Type of car, home, building, other): | | | | | | | | | | | | | | | | | | | | |
| Describe Area of Damage/Type of Damage: | | | | | | | | | | | | | | | | | | | | |
| License Plate#: | | Driver’s License #: | | | | | | | | | | Claimant Property Insured:  Yes  No | | | | | | | | |
| Insured with: | | | | | | | | | | Policy#: | | | | | | | Insurer Phone: | | | |
| Claimant Name: | | | | | | Phone#: | | | | | | | | | | | Bus./Cell #: | | | |
| Claimant Address: | | | | | | | | | | | | | | | | | | | | |
| Owner of Damaged Property (if Different): | | | | | | | | | | | | | | | | | | | | |
| Address of Owner (if necessary): | | | | | | | | | | | | | | | | | | | | Phone #: |
| Describe Claimant’s Property (Type of car, home, building, other): | | | | | | | | | | | | | | | | | | | | |
| Describe Area of Damage/Type of Damage: | | | | | | | | | | | | | | | | | | | | |
| License Plate#: | | | Driver’s License #: | | | | | | | | | Claimant Property Insured:  Yes  No | | | | | | | | |
| Insured with: | | | | | | | | | Policy#: | | | | | | | Insurer Phone#: | | | | |
| **UTILITY INFORMATION** | | | | | | | | | | | | | | | | | | | | |
| Utility Co.: | | | | Underground Notification#: | | | | | | | | | | | | | | Date of Notice: Pick Date: | | |
| **COMPANY INFORMATION** | | | | | | | | | | | | | | | | | | | | |
| Co. Property Description: Year: | | | | | Make/Model: | | | | | | | | | | Equip#: | | | | | |
| Estimated Value of Damage: | | | | | | | | | | | Rented/Leased  Yes  No | | | | | | | | | |
| Describe Damage/Theft: | | | | | | | | | | | | | | | | | | | | |
| Pictures Taken  Yes  No | | | | | | | | | | | Obtained Cost of Repairs?  Yes  No | | | | | | | | | |
| Police Agency Responded? | Yes  No | | | | | | Name of Agency & Office: | | | | | |  | | | | | | | |
| Police Report #: | | | | | | | Auto ID Code: | | | | | | | | | | | | | |
| **FORM INFORMATION** | | | | | | | | | | | | | | | | | | | | |
| Completed by: | | | | | | | Date Completed: | | | | | | | | | | | | Phone#: | |
| Person w/ Most Knowledge of Claim: | | | | | | | | | | | | | | | | | | | Phone#: | |
| Project Manager: | | | | | | | | | | | | | | | | | | | Phone#: | |
| Job Superintendent: | | | | | | | | | | | | | | | | | | | Phone#: | |
| Safety Manager: | | | | | | | | | | | | | | | | | | | Phone#: | |
| Safety Manager Remarks: | | | | | | | | | | | | | | | | | | | | |