|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Incident Type:** |[ ]  Work Comp |[x]  General Liab. | [x]  Auto Liab. | [ ] Prop/Equip/Asset |  |  |[x]  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:  |