Incident Reporting Form

Incident Type:	☐ Work Comp	☐ General Liab.	☐ Auto Liab.	☐Prop/Equip/Asset	☐ Bld Risk	☐ 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:

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Fatality ☐	Lost Time ☐	Restricted / Modified Duty ☐	Recordable Medical Treatment ☐	Non-Recordable Medical Treatment ☐	First Aid Only / FYI ☐	NWR ☐

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:

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:		

Incident Reporting Form

<table>
<tr><td>License Plate#:</td><td>Driver’s License #:</td><td colspan="2">Claimant Property Insured: ☐ Yes ☐ No</td></tr>
<tr><td colspan="2">Insured with:</td><td>Policy#:</td><td>Insurer Phone#:</td></tr>
<tr><th colspan="4">UTILITY INFORMATION</th></tr>
<tr><td>Utility Co.:</td><td colspan="2">Underground Notification#:</td><td>Date of Notice: Pick Date:</td></tr>
<tr><th colspan="4">COMPANY INFORMATION</th></tr>
<tr><td>Co. Property Description: Year:</td><td colspan="2">Make/Model:</td><td>Equip#:</td></tr>
<tr><td colspan="2">Estimated Value of Damage:</td><td colspan="2">Rented/Leased ☐ Yes ☐ No</td></tr>
<tr><td colspan="4">Describe Damage/Theft:</td></tr>
<tr><td colspan="2">Pictures Taken ☐ Yes ☐ No</td><td colspan="2">Obtained Cost of Repairs? ☐ Yes ☐ No</td></tr>
<tr><td>Police Agency Responded?</td><td>☐ Yes ☐ No</td><td>Name of Agency & Office:</td><td></td></tr>
<tr><td colspan="2">Police Report #:</td><td colspan="2">Auto ID Code:</td></tr>
<tr><th colspan="4">FORM INFORMATION</th></tr>
<tr><td>Completed by:</td><td colspan="2">Date Completed:</td><td>Phone#:</td></tr>
<tr><td colspan="3">Person w/ Most Knowledge of Claim:</td><td>Phone#:</td></tr>
<tr><td colspan="3">Project Manager:</td><td>Phone#:</td></tr>
<tr><td colspan="3">Job Superintendent:</td><td>Phone#:</td></tr>
<tr><td colspan="3">Safety Manager:</td><td>Phone#:</td></tr>
<tr><td colspan="4">Safety Manager Remarks:</td></tr>
</table>