

| Injured Employee Name: Employee Home Address: City/State/Zip: Date of Birth: City/State/Zip: Date of Hire: Time Employee Started Work: Time Employee Started Work: Onsite First Aid Given: Y or N Offsite Medical Treatment: Y or N Date Treatment Given: Shade the Specific Body Part (s) Injured: Left Abdomen Back Right Left Lower Right Left Wrists Chest, Ribs and/or Breastbone Right Left And/or Breastbone Face Right Hips Right Left Sea Right Hips Right Left Sea Right Hips Right Left Sea Right Hips Right Left Buttocks Shoulders Second Toe Scalp Fingers Skull Ander Right Right Left Buttocks Skull Ander Right Right Left Scalp Fingers Skull Ander Right Right Left Buttocks Shoulders Second Toe Stalp Fingers Right Left Buttocks Skull Ander Right Right Left Skull Ander Right Right Left Scalp Fingers Shoulders Second Toe Throw Knees Right Right Left Pinky Right Right Left Right Right Left Stalph Fourth Toe Stalph Fingers Shoulders Second Toe Throw Knees Right Right Left Pinky Right Right Right Left Pinky Right R | | EAA | MPLE SUPER | VISON ACCIL | JEINI/ | INCIDE | N 1 1 1 | NVLO | HUATI | א מוכ | EFUK | L |
|--|----------------|---|--|------------------|-------------|----------------------|----------------|-----------|---------------------------------|---------|--------------|------------------------|
| Project Manager: Superintendent/ Foreman: Exact Location of Incident: Street Address: City/State: Area: Type of Incident: (Select One) Injured Employee Name: Employee Home Address: City/State/Zip: Occupation/Job Title: Time Employee Started Work: Omsite First Aid Given: Y or N Onsite First Aid Given: Y or N If Yes, by Whom & What Given: Time Employee Started Work: AM or PM Onsite First Aid Given: Y or N If Yes, Treating Facility: (Name, City, State) Date of Birth: Time Employee Started Work: AM or PM Onsite First Aid Given: Y or N If Yes, Treating Facility: (Name, City, State) Date of Hire: Time Employee Started Work: List PPE worn at the time of incident: Shade the Specific Body Part (s) Injured: Head Elbows Brain Left Abdomen Right Abdomen Right Lower Legs Right Back Right Lower Legs Right Rig | 4 | Date of Incident: | | | Time: | Γime: AM or PM Day o | | Day of W | f Week | | | |
| Project Manager: Superintendent/ Foreman: Exact Location of Incident: Street Address: City/State: Area: Type of Incident: (Select One) First Aid Only Non-Recordable (Medical Treatment) Injured Employee Name: Imply Home City/State/Zip: Occupation/Job Title: Time Employee Started Work: Omsite First Aid Given: Y or N Offsite Medical Treatment: Y or N If Yes, by Whom & What Given: Time Employee Started Work: Am or PM Onsite First Aid Given: Y or N If Yes, Treating Facility: (Name, City, State) Offsite Medical Treatment: Y or N Date Treatment Given: Shade the Specific Body Part (a) Injured: Head Elbows Errain Left Forearms Kight Left Left Left Forearms Kight Left Left Forearms Kight Left Left Forearms Kight Left Left Left Forearms Kight Left Left Forearms Kight Left Nose Scalp Figer Figer | | Date of Report: | | | | | | | Weather | } | | |
| Superintendent/ Foreman: Exact Location of Incident: Street Address: City/State: Are: Are There Any Witnesses? Y or N See Page 5 for Witnesses? Type of Incident: (Select One) WC GL Auw Equip Thetr/Vandalism Property Utili Injured Employee Name: Employee Name: Employee Home Address: City/State/Zip: Occupation/Job Title: Time Employee Started Work: Onsite First Aid Given: Y or N Offsite Medical Treatment: Y or N Offsite Medical Treatment: Y or N Date Treatment Given: Shade the Specific Body Part (s) Injured: Head Elbows Brain Left Abdomen Brain Left Right Lower Right Faces Right Lower Right Lower Right Lower Right Peks Shaull Index Mouth or Throat Address Shaull Index Right Fight Shaull Index Right Fight Shaull Index Right Right Left Right Right Right Left Right Ri | AT. | Project Manager: | | | | | | | | | | |
| City/State: Area: Type of Incident: (Select One) WC GL Auto Equip Theft/Vandalism Property Utilistructions Type of Incident: (Select One) WC GL Auto Equip Theft/Vandalism Property Utilistructions Injured Employee Name: Injured Employee Name: Employee Home Address: City/State/Zip: Occupation/Job Title: Time Employee Started Work: Onsite First Aid Given: Y or N Onsite First Aid Given: Y or N If Yes, by Whom & What Given: Time Employee Started Work: AM or PM Onsite First Aid Given: Y or N If Yes, Treating Facility: (Name, City, State) Date Treatment Given: Shade the Specific Body Part (s) Injured: Head Elbows Brain Left Abdomen Left Ears Right Back Bright Left Procearms Right Left Sight Left Addle Left Middle Left Sight Left Sight Left Syaw(Chin Hands Nose Right Shoulders Scalp Fingers Skull Index Right Left Shall Index Right Problem Shoulders Scalp Fingers Skull Index Right Left Problem Right Left Shoulders Scalp Fingers Left Problem Right Left Problem Right Left Shoulders Scalp Fingers Left Problem Right Left Problem Right Left Problem Right Problem Right Left Problem Right Problem Rig | D | Superintendent/ Foreman: | | | | | | | , | | | |
| City/State: Area: Type of Incident: (Select One) WC GL Auto Equip Theft/Vandalism Property Utilistructions Type of Incident: (Select One) WC GL Auto Equip Theft/Vandalism Property Utilistructions Theft/Vandalism Property Utilistructions Injured Employee Name: Injured Employee Name: Employee Home Address: City/State/Zip: Occupation/Job Title: Time Employee Started Work: Onsite First Aid Given: Y or N Offsite Medical Treatment: Y or N Date Treatment Given: Shade the Specific Body Part (s) Injured: Head Elbows Brain Left Abdomen Left Ears Right Back Brain Left Ears Right Left Forearms Right Left Forearms Right Left Sight Left Adde Lower Legs Left By Middle Left Face Right Flingers Scalp Fingers Shoulders Second Toe Therm Middle Left Pinkly Right Fourth Toe Left Finkly Right Fourth | CT | Exact Location of Incident: | | | | | | | l: Y or N | | | |
| City/State: Area: Type of Incident: (Select One) WC GL Auto Equip Theft/Vandalism Property Utilistructions Type of Incident: (Select One) WC GL Auto Equip Theft/Vandalism Property Utilistructions Theft/Vandalism Property Utilistructions Injured Employee Name: Injured Employee Name: Employee Home Address: City/State/Zip: Occupation/Job Title: Time Employee Started Work: Onsite First Aid Given: Y or N Offsite Medical Treatment: Y or N Date Treatment Given: Shade the Specific Body Part (s) Injured: Head Elbows Brain Left Abdomen Left Ears Right Back Brain Left Ears Right Left Forearms Right Left Forearms Right Left Sight Left Adde Lower Legs Left By Middle Left Face Right Flingers Scalp Fingers Shoulders Second Toe Therm Middle Left Pinkly Right Fourth Toe Left Finkly Right Fourth | ROJE | Street Address: | | | | | | | o , | Proje | . | |
| Type of Incident: (Select One) Tipe of Incident: (Select One) The Incident: (Select | Ь | City/State: | | | | | | | | | l c p | F.C. WILL |
| Injured Employee Name: Employee Home Address: | • | Area: | | <u> </u> | | Are There | Any W | Vitnesse | es? Y or N | | | |
| Injured Employee Name: Employee Home Address: City/State/Zip: Occupation/Job Title: Time Employee Started Work: Onsite First Aid Given: Y or N Offsite Medical Treatment: Y or N If Yes, by Whom & What Given: Offsite Medical Treatment: Y or N Date Treatment Given: Shade the Specific Body Part (s) Injured: Head Elbows Trunk Lower Legs Brain Left Abdomen Back Right Left Proceams Right Left Wrists Chest, Ribs Foot and/or Breastbone Right Left Butcoks Big Toe Scalp Finger Shoulders Scalp Finger Skull Index Right Nose Scalp Finger Skull Index Right Left Pinky Right Left Pinky Right Left Pinky Right Left Pinky Right Fourth Toe Left Pinky P | | Type of Incident | (Select One) | WC GL | Auto | Equip | Theft | /Vandalis | sm | Proper | ty | Utility |
| Employee Home Address: City/State/Zip: | Inc | cident Designation | : (circle) First | Aid Only Non-Red | cordable (/ | Medical Treatm | nent) R | estricted | d Work Rec | ordable | e (Medical T | Treatment) (Lost Time) |
| Employee Home Address: | | Injured Employee Name: | | | | | | | | | | |
| Address: City/State/Zip: Phone: Occupation/Job Title: Years Experience: Date of Hire: Time Employee Started Work: AM or PM Onsite First Aid Given: Y or N Offsite Medical Treatment: Y or N Date Treatment Given: Shade the Specific Body Part (s) Injured: Head Elbows Trunk Lower Legs Brain Left Abdomen Left Right Left Forearms Right Left Eyes Right Left Ankles Lower Right Left Ankles Lower Right Left Ankles Right Left Ankles Lower Right Left Ankles Lower Right Left Ankles Right Left Ankles Lower Right Left Ankles Right Hips Right Shoulders Second Toe Scalp Fingers Left Third Toe Skull Index Right Fourth Toe Skull Index Right Fourth Toe Right Left Pinky Right Ri | • | Employee Home Street: | | | | | | | Date of Birth: | | | |
| Time Employee Started Work: Onsite First Aid Given: Y or N Offsite Medical Treatment: Y or N Date Treatment Given: Shade the Specific Body Part (s) Injured: Head Elbows Brain Left Abdomen Left Forearms Right Left Forearms Right Left Wrists Chest, Ribs Foot Right Left Saw/Chin Hands Nose Right Shoulders Scalp Fingers Skull Index Right Nose Scalp Fingers Skull Index Right Right Left Right Right Left Right Right Shoulders Scalp Fingers Right Left Right Right Right Right Right Right Shoulders Scalp Fingers Right Left Right Righ | | Address | | | | | | Phone: | | | | |
| Onsite First Aid Given: Y or N Offsite Medical Treatment: Y or N Date Treatment Given: Shade the Specific Body Part (s) Injured: Head Elbows Trunk Left Abdomen Left Ears Right Left Middle Left Eyes Right Lower Right Left and/or Breastbone Left Face Right Left Shoulders Shoulders Scalp Fingers Left Buttocks Big Toe Skull Index Right Right Left Shoulders Scalp Fingers Left Right Right Foreth Right Left Shoulders Scalp Fingers Left Right Right Right Fourth Toe Neck Middle Left Left Left Shoulders Scalp Fingers Left Third Toe Skull Index Right Fourth Toe Neck Middle Left Left Left Left Right Fourth Toe Neck Middle Left Left Left Left Shoulders Scalp Fingers Left Third Toe Skull Index Right Fourth Toe Neck Middle Left Left Left Left Right Fourth Toe Neck Middle Left Left Left Right Fourth Toe Neck Middle Left Left Pinky Right Rig | | Occupation/Job Title: | | | | Years Experience: | | | Date of Hire: | | | |
| Offsite Medical Treatment: Y or N Date Treatment Given: Shade the Specific Body Part (s) Injured: Head Elbows Trunk Left Abdomen Left Ears Right Left Middle Left Middle Left Eyes Right Left and/or Breastbone Left Face Right Left and/or Breastbone Left Hips Right Left Shoulders Scalp Fingers Left Third Toe Skull Nose Right Right Pourth Toe Kingly Right Left Right Pourth Toe Skull Neck Middle Legs Little Toe Arms Right Right Pourth Toe Left Pinky Right Right Left Arms Right Right Pourth Toe Left Pinky Right Pink | | Time Employee Started Work: AM or PM | | | | | | | | | | |
| Offsite Medical Treatment: Y or N Date Treatment Given: Shade the Specific Body Part (s) Injured: Head Elbows Trunk Lower Legs Brain Left Abdomen Left Ears Right Back Right Left Middle Left Right Left Middle Left Right Left and/or Breastbone Left Face Right Hips Right Jaw/Chin Hands Pelvis Toes Mouth or Throat Left Buttocks Big Toe Skull Index Right Fourth Toe Skull Index Right Fourth Toe Neck Middle Legs Little Toe Arms Ring Left Pinky Right Knees List PPE worn at the time of incident: INCIDENT TRACKI (See Page 6 for codes) Body Part: Injury: Detailed Description of Injury: Detailed Description of Injury: Toes Buttocks Big Toe Second Toe Skull Index Right Fourth Toe Neck Middle Legs Little Toe Arms Ring Left Finky Right Finky Righ | | Onsite First Aid Given: Y or N | | | | | | | | | | |
| Date Treatment Given: Shade the Specific Body Part (s) Injured: | | Offsite Medical Treatment: Y or N | | | | es, Treating | g Facil | lity: (N | ame, City, | State) | | |
| Brain Left Abdomen Left Right Injury: Left Forearms Upper Ankles Left Wrists Chest, Ribs Foot Right Left and/or Breastbone Left Right Left Shoulders Second Toe Scalp Fingers Left Third Toe Skull Index Right Legs Little Toe Brain Left Abdomen Left Injury: Injury: Detailed Description of Injury: Detailed Description of Injury: Injury: Detailed Description of Injury: Detailed Description of Injury: Injury: Detailed Description of Injury: Detailed Description of Injury: Injury: Detailed Description of Injury: Detailed Description of Injury: Injury: Detailed Description of Injury: Injury: Detailed Description of Injury: Detailed Description of Injury: Injury: Injury: Injury: Detailed Description of Injury: Injury: Detailed Description of Injury: Injury: Injury: Injury: Detailed Description of Injury: | RY | Date Treatment Given: | | | | | | | | | | |
| Brain Left Abdomen Left Right Injury: Left Forearms Upper Ankles Left Wrists Chest, Ribs Foot Right Left and/or Breastbone Left Right Left Shoulders Second Toe Scalp Fingers Left Third Toe Skull Index Right Legs Little Toe Brain Left Abdomen Left Injury: Injury: Detailed Description of Injury: Detailed Description of Injury: Injury: Detailed Description of Injury: Detailed Description of Injury: Injury: Detailed Description of Injury: Detailed Description of Injury: Injury: Detailed Description of Injury: Detailed Description of Injury: Injury: Detailed Description of Injury: Injury: Detailed Description of Injury: Detailed Description of Injury: Injury: Injury: Injury: Detailed Description of Injury: Injury: Detailed Description of Injury: Injury: Injury: Injury: Detailed Description of Injury: | NJU | Shade the Specific Body Part (s) Injured: | | | | | | | INC | | | |
| Ears Right Back Right Ankles Left Forearms Upper Ankles Right Left Middle Left Eyes Right Lower Right Left Wrists Chest, Ribs Foot Right Left and/or Breastbone Left Face Right Hips Right Jaw/Chin Hands Pelvis Toes Mouth or Throat Left Buttocks Big Toe Scalp Fingers Left Third Toe Skull Index Right Fourth Toe Neck Middle Legs Little Toe Arms Ring Left Left Pinky Right Right Right Right Right Fourth Toe Left Pinky Right Righ | | | | | | | | | | | | |
| Left Right Left Middle Left Right Left Wrists Chest, Ribs Foot Right Left and/or Breastbone Left Face Right Hips Right Jaw/Chin Hands Pelvis Toes Mouth or Throat Left Buttocks Big Toe Nose Right Shoulders Second Toe Skull Index Right Fourth Toe Neck Middle Legs Little Toe Arms Ring Left Left Pinky Right Right Right Shoes **For PA claims only: The employee | | | A CONTRACTOR OF THE CONTRACTOR | | | | | | Injury: | | | |
| Eyes Right Lower Right Left Wrists Chest, Ribs Foot Right Left and/or Breastbone Left Face Right Hips Right Jaw/Chin Hands Pelvis Toes Mouth or Throat Left Buttocks Big Toe Nose Right Shoulders Second Toe Scalp Fingers Left Third Toe Skull Index Right Fourth Toe Neck Middle Legs Little Toe Arms Ring Left Left Pinky Right Right Knees | 7 | Left | Forearms | | | Ankles | | Det | Detailed Description of Injury: | | | |
| Left Wrists Chest, Ribs Foot Right Left and/or Breastbone Left Face Right Hips Right Jaw/Chin Hands Pelvis Toes Mouth or Throat Left Buttocks Big Toe Nose Right Shoulders Second Toe Scalp Fingers Left Third Toe Skull Index Right Fourth Toe Neck Middle Legs Little Toe Arms Ring Left Left Pinky Right Fight Knees | \overline{C} | | | | | | | | | | | |
| Right Left and/or Breastbone Left Face Right Hips Right Jaw/Chin Hands Pelvis Toes Mouth or Throat Left Buttocks Big Toe Nose Right Shoulders Second Toe Scalp Fingers Left Third Toe Skull Index Right Fourth Toe Neck Middle Legs Little Toe Arms Ring Left Left Pinky Right Right Knees | S | | | | | | | | | | | |
| Face Right Hips Right Jaw/Chin Hands Pelvis Toes Mouth or Throat Left Buttocks Big Toe Nose Right Shoulders Second Toe Scalp Fingers Left Third Toe Skull Index Right Fourth Toe Neck Middle Legs Little Toe Arms Ring Left Left Pinky Right Fight Thumb Knees | N, | | | | stbone | | | | | | | |
| Mouth or Throat Left Buttocks Big Toe Nose Right Shoulders Second Toe Scalp Fingers Left Third Toe Skull Index Right Fourth Toe Neck Middle Legs Little Toe Arms Ring Left Left Pinky Right Fight Thumb Knees | H | | | Hips | | | | | | | | |
| Nose Right Shoulders Second Toe Scalp Fingers Left Third Toe Skull Index Right Fourth Toe Neck Middle Legs Little Toe Arms Ring Left Left Pinky Right Fight Thumb Knees | | | | | | | | | | | | |
| Scalp Fingers Left Third Toe Skull Index Right Fourth Toe Neck Middle Legs Little Toe Arms Ring Left Left Pinky Right Pight Thumb Knees Ω Ω **For PA claims only: The employee | | | | | | | | | | | | |
| Skull Index Right Fourth Toe Neck Middle Legs Little Toe Arms Ring Left Left Pinky Right Pight Thumb Knees | | | | | | | | | | | | |
| Arms Ring Left Left Pinky Right Pight Thumb Knees Ω Ω **For PA claims only: The employee | | Skull | Index | Right | | Fourth To | e | | | | | |
| Left Pinky Right Fight Thumb Knees Q \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ | | | | | | Little Toe | | | | | | |
| **For PA claims only: The employe | | | | | Si Si | _ | | | | | | |
| Left Right Supervisor must sign the attached M Treatment Rights form. | | Right | Thumb | Knees Left | | | A. | | supervisor 1 | must si | gn the atta | |



EXAMPLE SUPERVISOR ACCIDENT/INCIDENT INVESTIGATION REPORT

| | Property Owner Name: | | | | | | | |
|-------------------|---|------------------------------------|----------|---|------|----------------------|--|--|
| | _ | Street: | | | | | | |
| | Property Owner City/State: | | | | | | | |
| | Address: | City/State: | | | | | | |
| . . | | | | | | | | |
| GENERAL LIABILITY | Detailed Descri | iption of Damages: (draw dia | | | | | | |
| Ä | Estimated Dan | nage: \$ | Pictures | s Taken: Yor N | | | | |
| E | | If Utility | Strike P | Please Indicate the Following | : | | | |
| | Electrical LinePhone LineGas Line Water LineCable LineOther | | | Marked Mismarked Unmarked | | | | |
| | | | | Was DigSafe Call Made?: Y or N By Whom: | | | | |
| | | | 1 | Date Called In:Ti | cket | :# | | |
| | Operator Name | <u> </u> | | Equipment / Vehicle Number: | | | | |
| | Operator Name: | | | Equipment / Veincle Number. | | | | |
| | | | | Rental: Y or N | | Rented From: | | |
| | Rental Compan | ny Phone: | | | Es | timated Damage (\$): | | |
| | Did Operator obey all applicable safety rules? Y or N - If NO, list exceptions: | | | | | | | |
| L | Did Authorities Respond (fire, police, | | | Responding Authority: | | | | |
| MENT | ambulance, etc)? Y or N | | • | Contact Person Name: | | | | |
| W | | |] | Phone Number: : | | | | |
| EQUIP | Was there Property Damage: Y or N If yes, please specify: | | | Report / Incident Number: | | | | |
| | For Vehicle Damag | ge, Describe/Draw the Specific are | ed: | | | | | |
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EXAMPLE SUPERVISOR ACCIDENT/INCIDENT INVESTIGATION REPORT

TO BE COMPLETED FOR ALL INCIDENTS

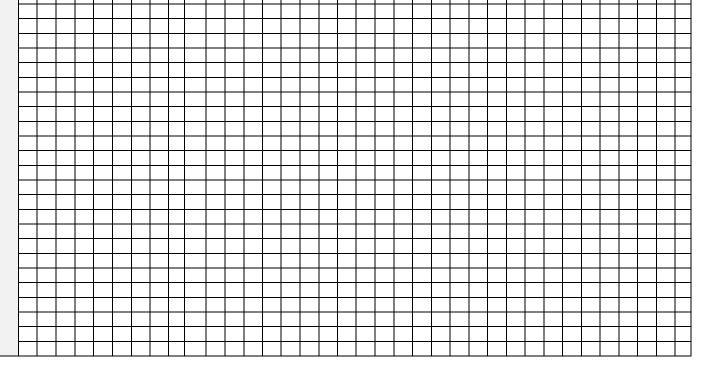
Describe in detail the circumstances of the incident. Give a chronological sequence of events. If materials, equipment and/or vehicles were involved, start before they were brought to the incident scene and describe the who, what, where, when, and how the incident happened in your words below (specifically detail who, what, where, when, how, and why you believe the incident happened):

TO BE COMPLETED FOR ALL INCIDENTS

(Show position and any relative distances of employee(s), vehicle(s), equipment, pedestrians, property, etc., and indicate an arrow of direction for each if travel or moving equipment was involved):

DIAGRAM OF INCIDENT

DESCRIPTION OF INCIDENT





EXAMPLE SUPERVISOR ACCIDENT/INCIDENT INVESTIGATION REPORT

| | Was there any type of planning (ex: Pre-con, daily huddle, toolbox talk, etc) that discussed the potential for this incident, and the safe work procedures to be followed to prevent it? YES or NO Please attach a copy of document to support your findings. |
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| | with procedures to be journed to procedure 1120 of 110 Trease actually copy of avenuent to support your intensign |
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| LESSONS LEARNED | |
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| What was the Root Cause(s) of the Incident? |
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| Contributing | g Factor(s) to the Inci | dent: (weather, lighting, tra | affic control plan, commun | ication of hazards, etc.) | |
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| Corrective Actions(s) Taken or Planned What was/will be done? | By Whom | Estimated Completion Date | Actual Completion Date | Confirmed Initials | | | |
|---|---------------------------------------|-------------------------------------|---------------------------|-----------------------|--|--|--|
| | | | | | | | |
| Incident discussed with employee to prevent recurrence? | Yes No | | | | | | |
| Any disciplinary action taken? | Yes No | | | | | | |
| If yes, describe what type: | | | | | | | |
| Possible actions to be taken to pre- | · | action) | | | | | |
| A. Repair/replace or modify equip. | F. Ergonomic enhancement | | K. Retraining o | f employees | | | |
| B. Improve job site housekeeping | G. Establish a Safe Work Procedure | | L. Preventive maintenance | | | | |
| C. Update inspection procedure | H. Improve environmental conditions | | M. Improve ent | forcement | | | |
| D. Eliminate/reduce congestion | I. Require/change PPE | | N. Modify proc | edure & | | | |
| E. Change design | | O. Reassign employee to another job | | | | | |
| Follow Up Communication | | | | | | | |
| Yes No In | jury site reviewed by superv | isor/safety represe | entative with empl | oyee | | | |
| Yes No Su | pervisor reviewed incident | with employees | | | | | |
| Yes No Lessons learned posted in safety review. If yes, what? | | | | | | | |
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APPENDIX N – EXAMPLE SUPERVISOR ACCIDENT/INCIDENT INVESTIGATION REPORT EMPLOYEE / WITNESS STATEMENT FORM

| TO BE COMPLETED FOR WORKERS' COMPENSATION INCIDENTS ONLY | | | | | |
|--|---|-----------------------|-------|--|--|
| Witness Name: (Please Print) | Work Ph: | | | | |
| Witness Address: | | | | | |
| Date and Time of incident: Supervisor Notified on Date and Time: | am / pm | List other Witnesses: | | | |
| | am / pm | | | | |
| This is what happened (include who, what, whe | re, when, how and why): | | | | |
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| Do you recall anything unusual or unexpected t | hat happened? Yes or No If Yes Explain: | | | | |
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| | | | | | |
| Are there work conditions that contributed to th | is injury? Yes or No If Yes Explain | | | | |
| | , , | | | | |
| | | | | | |
| How would you prevent this incident from happ | pening in the future? | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| PLEASE USE AND ATTACH ADDITIONAL PAGES IF NECESSARY | Witness Signature: | | Date: | | |



APPENDIX N - EXAMPLE SUPERVISOR ACCIDENT/INCIDENT INVESTIGATION REPORT

| PARTICIPANTS OF THE INCIDENT ANALYSIS | MANAGEMENT REVIEW | | |
|---------------------------------------|-------------------|-------------------------|------|
| Name/Title or Trade | Date | Name | Date |
| | | Foreman: | |
| | | Superintendent: | |
| | | General Superintendent: | |
| | | Safety Manager: | |
| Employee Signature: (print) | | Project Manager: | |
| Employee Signature: | | Other: | |

DISTRIBUTE SUPERVISOR'S ACCIDENT/INCIDENT INVESTIGATION REPORT TO THE FOLLOWING: Construction Manager, Project Safety Manager, Owner's Project Manager, and HUEHS.

ACCIDENT TYPES

- 1 Falls On Same Level: Slips, trips, or falls on foot level surfaces such as the ground, floors, stairs, work platforms, or rebar. Includes slips on mud, liquids, ice and other slippery surfaces and trips over obstacles such as tools, cords, rocky or uneven surfaces.
- 2 Falls From Elevations: Falls to a lower level from elevated surfaces. Includes falls from structural steel, scaffolds, work platforms, form work, equipment, etc.
- 3 Falls From Ladders: Falls from portable or fixed ladders including stepladders.
- 4 Falls into Opening: Falls into floor holes, openings in the ground (i.e., caisson holes, unguarded ditch/excavation, etc.)
- 5 Material Handling Manual: Injuries from manually moving tools, equipment, or material. This includes over exertion due to lifting or carrying material manually and usually results in sprains/strains of the back and other body parts.
- 6 Caught In/Under/Between: Injuries caused by power tools or equipment and resulting in crushing or pinching of fingers and/or other body parts.
- 7 Struck By/Against Object: Injuries caused by employees being struck by flying or moving objects, or injuries caused by employees bumping into/against stationary objects.
- 8 Struck By Flying Object-Eye: Eye injuries only caused by grinding, chipping or other operations. Includes windblown dust and foreign bodies entering the eye.
- 9 Occupational Illness includes the following:
 - a. Skin diseases/disorders poision ivy, heat rash, contact dermatitis, etc.
 - b. Dust disease of lungs silicosis, asbestosis, etc.
 - c. Poisoning due to toxic materials lead or other metal poisoning and poisoning by carbon monoxide or other gases
 - d. Illness due to physical agents sunstorke, heat exhaustion, frostbite, or other illnesses caused by temperature extremes or environmental conditions
 - e. Disorders caused by repeated trauma carpal tunnel syndrome, noise-induced hearing loss.
- 10 Electrical Contact: Injuries resulting in electrical shock caused by flow of electric current through the body. Includes shock from power tools, electrical cords, and contact with overhead power lines.
- 11 Burns: Injuries resulting in thermal (heat) or chemical burns. Includes burns caused by welding/cutting operations, or use of chemicals.
- 12 Miscellaneous: Avoid using this category. Only mark this category if the injury or illness doesn't fit into another general accident type

| CAUS | SE CODES: | | PART OF BODY: | |
|------|---|---|----------------------|-----------------|
| 1. | Improper handing of material | Defective equipment/tools | 1. Ankle | 9. Groin |
| 2. | Improper lifting | 11. Improper/defective walk area | 2. Arm | 10. Hand/Finger |
| 3. | Improper use of tools/equipment | Slippery/rough surface | 3. Back | 11. Head |
| 4. | Making safety devices inoperative | Poor housekeeping | 4. Chest | 12. Knee |
| 5. | Failure to use PPE | Improperly piled material | 5. Elbow | 13. Leg |
| 6. | Taking unsafe position | Windblown dust | 6. Eye | 14. Neck |
| 7. | Clean, adjust, etc. of moving equipment | Congested area | 7. Face | 15. Shoulder |
| 8. | Horseplay, distracting, fighting | 17. Poor working conditions | 8. Foot/Toe | 16. Wrist |