

# ACCIDENT / INCIDENT REPORT

MINOR

JOB NUMBER \_\_\_\_\_ DATE \_\_\_\_\_ SHEET \_\_\_\_\_

JOB NAME \_\_\_\_\_ SUPERINTENDENT \_\_\_\_\_

1. WAS ANYONE INJURED?  YES - ACCIDENT REPORT  NO - INCIDENT REPORT

2. Name Of Employee Injured \_\_\_\_\_ Employer\* \_\_\_\_\_

Describe Injury. \_\_\_\_\_

Was Medical Attention Required? Describe. \_\_\_\_\_

Treated By \_\_\_\_\_ Location \_\_\_\_\_

3. Name Of Witness(es) \_\_\_\_\_ Employer \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

4. Describe Work Being Performed At The Time Of The Accident / Incident And Applicable Safety Rules

\_\_\_\_\_  
\_\_\_\_\_

5. Were Safety Rules Violated?  NO  YES (If YES Describe Violation)

\_\_\_\_\_  
\_\_\_\_\_

6. Describe What Happened In Sequence.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

7. What Caused The Accident / Incident

\_\_\_\_\_  
\_\_\_\_\_

8. Describe What Was Done Or Can Be Done To Prevent This From Taking Place Again.

\_\_\_\_\_  
\_\_\_\_\_

9. Project Superintendent - Describe Observations And Immediate Response Actions Taken

\_\_\_\_\_  
\_\_\_\_\_

