HELPSIDE

FIRST REPORT OF INCIDENT

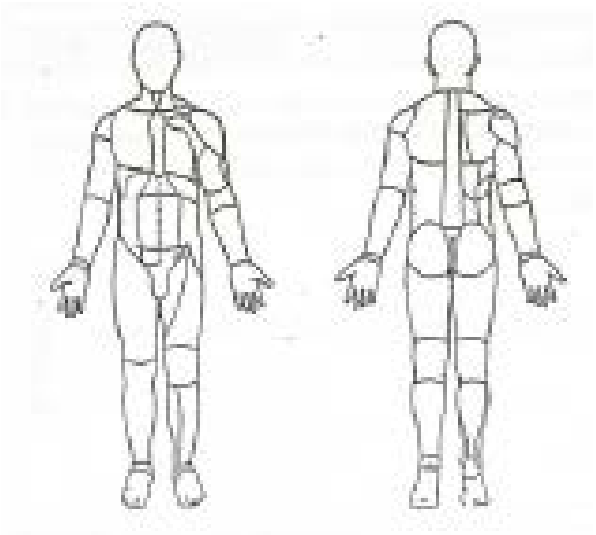
Employee Data

Employee Name:		SSN:	Sex: ☐ M ☐ F
Employee Home Address:		Phone:	
		Date of Birth:	
Position:		Years at company:	Date of Hire:

Project Data

Date of Incident:		Time: ☐AM ☐PM			Day of Week:	
Date Reported to Company:		Division:			Project:	
Foreman:		Superintendent:			PM:	
Incident Type (circle one)	**WC**	**GL**	**Auto**	**Utility**	**Equip**	**Near Miss**
Were There Any Witnesses? ☐Yes ☐ No		Total Number of Witnesses:			See Page 5 for Witness Instructions	
Drug Screen(s) Administered? ☐Yes ☐ No			Was utility line marked? ☐Yes ☐ No			
If yes, list employees:			Blue stake #:			
Is a JHA attached? ☐Yes ☐ No						

Personal Injury - WC

On Site First Aid Given? ☐Yes ☐ No	If Yes, by Whom:
Offsite Medical Treatment Provided? ☐Yes ☐ No	If Yes, Treating Facility:
Date of Offsite Treatment:	Treating Facility Phone:
Shade the Specific Body Part(s) Injured: 	Detailed Description of Injury:
	List any PPE used at the time of incident:

Incident Designation	
☐ First Aid Only	☐ Restricted Work
☐ Non-Recordable - Medical	☐ Recordable - Lost Time
☐ Recordable - Medical	☐ Claim Denied

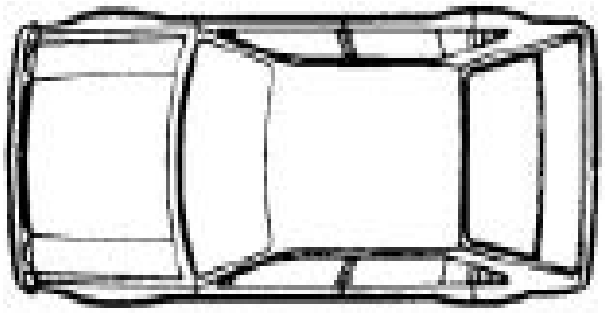
General Liability

Name of Injured/Property Owner:	Phone:
Injured/Property Owner Address:	Estimated Damages:
Detailed Description of Damages: (Draw a diagram on page 3)	

Auto & Equipment Damage

Unit Description:	Unit #: Rental?: ☐Yes ☐ No
Rental Company (if applicable): Rental Company Phone:	Estimated Damage:
Did the Driver/Operator obey all applicable safety rules and/or D.O.T. Motor Vehicle Laws? ☐Yes ☐ No If No, list expectations:	
Did authorities (police, fire, ambulance, etc.) respond on site?	Responding Authority: Contact Person: Phone:
Was there other vehicle or property damage?: ☐Yes ☐ No	Owner Name: License # and & State:

For auto damage, shade the specific area(s) damaged.



FRONT

USE ARROW TO SHOW FIRST IMPACT (SHADE IN DAMAGED AREA)

- ☐ Vehicle towed
- ☐ Rollover
- ☐ Under car
- ☐ Totaled
- ☐ Unknown

Description of Incident	**Complete this section for ALL incidents!** Describe in detail the circumstances of the incident. Provide a chronological sequence of events. Take photos to help in the documentation process. If materials, equipment and/or vehicles were involved, begin your account prior to when they were brought to the scene and describe the who. what, where, when and how the incident happened in your own words below.
Description of Incident	**Complete this section for ALL incidents!** Show the position and relative distances of employee(s), vehicle(s), equipment, pedestrians, property, etc. Indicate an arrow of direction for each.

Causal Factors	Causal Factor (Human Factor):
	Causal Factor (Management Systems):
	Causal Factor (Environment):
	Causal Factor (Tools/Equipment):
Corrective Action	Corrective Action (Human Factor):
	Assigned to:
	Corrective Action (Management Systems):
	Assigned to:
	Corrective Action (Environment):
	Assigned to:
	Corrective Action (Tools/Equipment):
	Assigned to:

Incident Analysis Participants		**Management Review**	
Employee Print Name:		Safety Manager Print Name:	
Employee Signature:	Date:	Management Signature:	Date:

Incident Witness Statement Form		
Witness Name:		
Witness Address:		
Witness Phone Numbers	Work:	Home:
Location of Incident/Accident		
Time of Incident/Accident: ☐AM ☐PM		Date of Incident/Accident:
Description of the Incident/Accident:		