

IndustrySafe

Mobile Incident Form

Default Field Statuses

This guide lists the Initial Incident and Incident Investigation form fields that are enabled by default within IndustrySafe’s mobile app.

Please note that fields with a default status of “enabled” will only display within the mobile app if they are also enabled within the IndustrySafe web application’s incident forms.

Field Name	Default Status
Basic Information Section	Enabled
Involved Employee Name	Enabled
Facility	Enabled
Section	Disabled
Location	Disabled
Department	Disabled
GPS Location	Enabled
Worker Type	Disabled
Date of Incident	Enabled
Time of Incident	Enabled
Incident Type	Enabled
Was This Incident Work Related?	Enabled
Was a Vehicle Involved?	Enabled
Was an Aircraft Involved?	Enabled
Was an employee or directly supervised contractor injured?	Enabled
Was a Non-Employee Injured?	Enabled
Was Property Damage Involved?	Enabled
Initial Incident Description	Enabled
Severity	Disabled
Probability	Disabled
Preparer’s Name	Disabled
Supervisor’s Name	Disabled
Incident Details Section	Enabled
Reported to: Name	Enabled

Field Name	Default Status
Location On	Disabled
Location At	Disabled
City	Disabled
State	Disabled
Date Reported	Disabled
Shift	Enabled
Description of Location	Enabled
Weather	Disabled
Lighting	Disabled
Description of Environmental Conditions	Disabled
Description of Incident	Disabled
Vehicle Involved Section	Enabled
Type of Incident	Disabled
Vehicle Action	Enabled
Unit Number	Enabled
Vehicle Type	Enabled
Vehicle Make	Enabled
Vehicle Model	Enabled
Vehicle Year	Enabled
License Plate Number	Disabled
License Plate State	Disabled
Vehicle Identification Number	Enabled
Vehicle Weight Class	Disabled
Name of Driver	Enabled
CDL Number	Disabled
Number of Passengers	Disabled
Names of Passengers	Disabled
Number of Fatalities	Disabled
Number of people Injured who immediately received medical treatment away from the scene of the accident	Disabled
Did the Vehicle Incur disabling damages as a result of the accident, requiring the vehicle to be transported away from the scene by a tow truck or other motor vehicle?	Disabled
Was Hazardous Material, other than fuel spilled from the fuel tanks of vehicle involved in the accident, released?	Disabled
Collision Type	Disabled
Collision Description	Disabled
Charge	Disabled

Field Name	Default Status
Select a Violation	Disabled
Violation Number	Disabled
Violation Description	Disabled
Points for this Violation	Disabled
Motor Vehicle Record	Disabled
Action or Discipline Date	Disabled
Other Vehicle Involved Section	Enabled
Vehicle Action	Enabled
Vehicle Make	Enabled
Vehicle Model	Enabled
Vehicle Year	Enabled
Number of Passengers	Enabled
Names of Passengers	Enabled
Did the Vehicle Incur disabling damages as a result of the accident, requiring the vehicle to be transported away from the scene by a tow truck or other motor vehicle?	Disabled
Driver Name	Enabled
Gender	Disabled
Date of Birth	Disabled
Address	Enabled
Phone Number	Enabled
Email Address	Disabled
Driver's License No.	Enabled
Driver's License State	Enabled
Does the Driver Own the Vehicle?	Enabled
Owner Name	Enabled
Address	Enabled
Phone Number	Enabled
Email Address	Disabled
Insurance Company	Enabled
Policy Number	Enabled
Witness Information Section	Enabled
Name	Enabled
Gender	Disabled
Date of Birth	Disabled
Address	Disabled
Phone Number	Disabled

Field Name	Default Status
Email Address	Disabled
Was Witness interviewed?	Disabled
Witness Statement	Enabled
Injury Section	Disabled
Number of Injuries	Disabled
Number of Injuries – Refused Aid	Disabled
Number of Injuries – First Aid	Disabled
Number of Injuries – Beyond First Aid	Disabled
Non-Employee Injury Section	Enabled
Name	Enabled
Gender	Disabled
Date of Birth	Disabled
Address	Disabled
Nature of Injury	Enabled
Was person transported from the scene for more medical attention?	Enabled
Was Aid Refused?	Enabled
Employee Injury Section	Enabled
Date of injury or onset of illness	Enabled
Did injury occur on premises?	Enabled
Was medical treatment received?	Enabled
Did injury occur on premises?	Enabled
Was medical treatment received?	Enabled
If refused, why?	Enabled
Initial Treatment	Enabled
Consequences of Injury/Illness	Disabled
Date of Death	Disabled
Date Range for Missed Days	Disabled
First Work Day with Missed Time	Disabled
Last Work Day with Missed Time	Disabled
Number of Work Days Missed	Disabled
Number of Work Hours Missed	Disabled
Lost Time Comments	Disabled
Date Range for Restricted Duty	Disabled
Date of Initial Diagnosis	Disabled
Classification of Injury/Illness	Enabled

Field Name	Default Status
Was injury or illnesses a needle stick or other sharp implement injury, hearing loss, or tuberculosis?	Enabled
Body Part Affected	Enabled
Side of Body Affected	Enabled
Nature of Injury	Enabled
Cause of Injury	Enabled
Specific Cause of Injury	Enabled
Specific Source of Injury	Enabled
Is injury expected to be disabling?	Enabled
Was employee exposed to a hazardous material?	Enabled
Medical Treatment Section	Enabled
Date of Treatment	Enabled
Was treatment given away from the worksite?	Enabled
Was employee treated in an emergency room?	Enabled
Was employee hospitalized overnight as an in-patient?	Disabled
Did the employee suffer an amputation, or lose an eye within 24 hours of the incident?	Disabled
Name of Physician or Other Health Care Professional	Disabled
Treatment Facility	Disabled
Name of Treatment Facility	Disabled
Street Address	Disabled
City	Disabled
State	Disabled
Zip Code	Disabled
Phone	Disabled
Recordkeeping and Reporting Section	Disabled
Date Reported to OSHA	Disabled
Time Reported to OSHA	Disabled
How Reported	Disabled
Reported by Name	Disabled
Reported by Employee ID	Disabled
Reported by Title	Disabled
Reported by Phone	Disabled
Comments	Disabled
Where did the incident occur?	Disabled
What was the employee doing just before the incident occurred?	Disabled
How did the injury occur?	Disabled

Field Name	Default Status
What was the injury or illness?	Disabled
What object or substance directly harmed the employee?	Disabled
Describe injury or illness, parts of body affected, and object/substance that directly injured or made person ill	Disabled
Is this a privacy case?	Disabled
Should this injury be redlined on the OSHA 300 log?	Disabled
If Yes, explain why this injury should be redlined	Disabled
Employee Work Behavior Section	Enabled
Time Employee Began Work	Enabled
Time Employee Ended Work	Enabled
Number of Hours Worked per Day	Enabled
Was an allegedly defective tool or equipment involved?	Enabled
If yes, explain how tool or equipment caused the illness/injury	Enabled
Was the alleged unsafe or defective tool or equipment reported?	Enabled
If yes, to whom and when	Enabled
Is employee trained and authorized to use the tool or equipment?	Enabled
Were safety rules and safe work practices being followed?	Enabled
If no, explain	Enabled
Were safe guards or safety equipment provided?	Enabled
Were they used?	Enabled
Was personal protective equipment required for this job?	Enabled
Identify required personal protective equipment	Enabled
Of the items listed above which ones were not being used by the employee?	Enabled
Did the employee's act or omission contribute to this alleged injury?	Enabled
If yes, explain	Enabled
Property Damage Section	Enabled
Estimated Property Damage	Enabled
Responders Section	Enabled
Did Fire / Emergency Medical Services respond to the incident?	Enabled
Fire / Medical Report #	Enabled
Did Police / Security respond to the incident?	Enabled
Police / Security Report #	Enabled
Incident Analysis Section	Disabled
Primary Cause	Disabled
Secondary Cause	Disabled
Immediate Cause	Disabled

Field Name	Default Status
Contributing Factor	Disabled
Root Cause	Disabled
Was a drug or alcohol test performed?	Disabled
Did the involved employee work the previous shift?	Disabled
Analysis of the Incident	Disabled
Other Parties' Version of the Incident	Disabled
Additional Remarks	Disabled
Employee Training History	Disabled
Charge	Disabled
Retraining Required?	Disabled
Recommended Retraining	Disabled
Report Status	Disabled