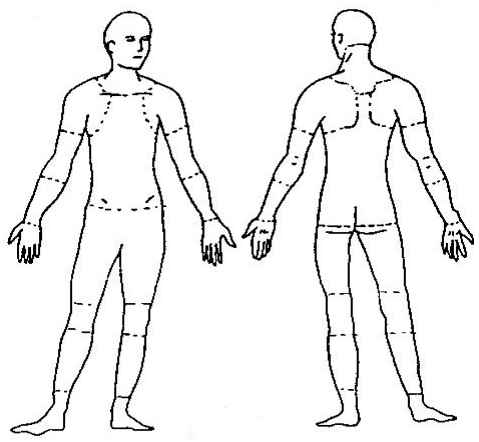
# Incident Report Form

| | | | |
|---|---|---|---|
| **Name of Person Completing this Report (Airswift):** | | **Position:** | |
| **Employee / Contractor Name:** | | **Job Title:** | |
| **Client / Project:** | | **Supervisor Name:** | |
| **Work Location:** | | | |
| **Who was the incident reported to?** | | **I am reporting a work-related:** ❑ Injury ❑ Illness ❑ Near miss | |
| **Name:** | | **Date of incident:** | |
| **Position:** | | **Time of incident:** | |
| **Where (exactly) did the incident happen:** | | **Who was present at the time of the incident (details of witnesses, if any)?** | |
| **Describe step-by-step what led up to the incident, attach additional pages and other evidence (photo's etc.) as appropriate:** | | | |
| **What were you doing at the time of the incident?** | | | |
| **Describe step by step the incident itself, attach additional pages and other evidence (photo's etc.) as appropriate:** | | | |

# Incident Report Form

| **INJURED EMPLOYEE(S) - *Complete this part for each injured employee*** | | |
|---|---|---|
| **Person 1** | | |
| **Name:** | **Sex:** ❑ Male ❑ Female | **Age:** |
| **Department and Job Title:** | | |

**Part of body affected: (shade all that apply)**



**Nature of injury: (most serious one)**

❑ Abrasion, scrapes
❑ Amputation
❑ Broken bone
❑ Bruise
❑ Burn (heat)
❑ Burn (chemical)
❑ Concussion (to the head)
❑ Crushing Injury
❑ Cut, laceration, puncture
❑ Hernia
❑ Illness
❑ Sprain, strain
❑ Damage to a body system:
❑ Other _____

**What was the result of the incident? (Please select all that apply)**

❑ First Aid Treatment ❑ Medical Treatment ❑ Restricted Duty ❑ Days away from work/ lost time ❑ Fatality

**If medical treatment was required, what treatment was this?**

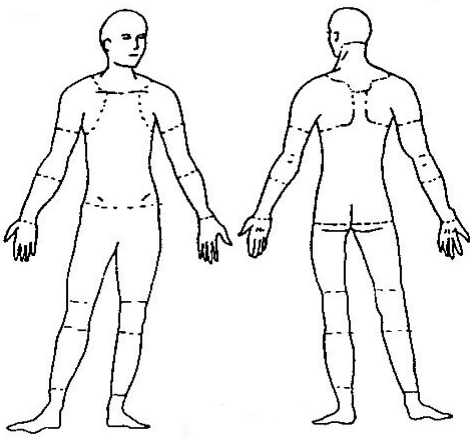
**How many days was the Contractor/Employee away from work?**

**How many days was the Contractor/Employee on restricted duty?**

# Incident Report Form

| **Person 2** | | |
|---|---|---|
| **Name:** | **Sex:** ❑ Male ❑ Female | **Age:** |
| **Department and Job Title:** | | |

**Part of body affected: (shade all that apply)**



**Nature of injury: (most serious one)**

❑ Abrasion, scrapes
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❑ Burn (heat)
❑ Burn (chemical)
❑ Concussion (to the head)
❑ Crushing Injury
❑ Cut, laceration, puncture
❑ Hernia
❑ Illness
❑ Sprain, strain
❑ Damage to a body system:
❑ Other _____

**What was the result of the incident? (Please select all that apply)**

❑ First Aid Treatment ❑ Medical Treatment ❑ Restricted Duty ❑ Days away from work/ lost time ❑ Fatality

**If medical treatment was required, what treatment was this?**

**How many days was the Contractor/Employee away from work?**

**How many days was the Contractor/Employee on restricted duty?**

# Incident Report Form

| **Why did the incident happen?** | |
|---|---|
| **Unsafe workplace conditions:**<br>(Check all that apply)<br><br>❑ Inadequate guard<br>❑ Unguarded hazard<br>❑ Safety device is defective<br>❑ Tool or equipment defective<br>❑ Workstation layout is hazardous<br>❑ Unsafe lighting<br>❑ Unsafe ventilation<br>❑ Lack of needed personal protective equipment<br>❑ Lack of appropriate equipment / tools<br>❑ Unsafe clothing<br>❑ No training or insufficient training<br>❑ Other: _____ | **Unsafe acts by people:**<br>(Check all that apply)<br><br>❑ Operating without permission<br>❑ Operating at unsafe speed<br>❑ Servicing equipment that has power to it<br>❑ Making a safety device inoperative<br>❑ Using defective equipment<br>❑ Using equipment in an unapproved way<br>❑ Unsafe lifting<br>❑ Taking an unsafe position or posture<br>❑ Distraction, teasing, horseplay<br>❑ Failure to wear personal protective equipment<br>❑ Failure to use the available equipment / tools<br>❑ Other: _____ |
| **How did the unsafe conditions occur?** | |
| **Were unsafe acts / conditions reported prior to the incident?** ❑ Yes ❑ No | |
| **Have there been similar incidents or near-misses prior to this one?** ❑ Yes ❑ No | |

# Incident Report Form

| **Corrective Action:** | | |
|---|---|---|
| **Immediate Action:** | | |
| **Action(s):** | **Responsible Party:** | **Date Taken:** |
| 1. | | |
| 2. | | |
| 3. | | |
| **Long-Term Action:** | | |
| **Action(s):** | **Responsible Party:** | **Target Date:** |
| 1. | | |
| 2. | | |
| 3. | | |
| **Measurement of Effectiveness** | | |
| **Corrective Action is Satisfactory:** ❑ Yes ❑ No | **Initials:** | **Date:** |
| If no, what further action is needed? | | |
| **Corrective Action Implemented:** ❑ Yes ❑ No | **Initials:** | **Date:** |
| **Investigation Closed:** ❑ Yes ❑ No | **Initials:** | **Date:** |