



INCIDENT INVESTIGATION REPORT

This Incident Report is to be filled out for ALL types of incidents involving personnel and equipment.

***Incident must be reported within 4 hours and investigation must be completed and submitted within 24 hours.**

Type of Incident:

- ☐ First Aid
☐ Recordable
☐ Lost Time
☐ Property

(Office Use Only)

EMPLOYEE INFORMATION:

Employee Name: _____ Clock Number: _____ Dept. Number: _____
Job Title: ☐ Journeyman ☐ Apprentice ☐ Other: _____ Age: _____
Trade: ☐ Pipe Fitter ☐ Plumber ☐ Sheet Metal ☐ Controls ☐ Electrician ☐ Other: _____
Home Address: _____ Sex: M ☐ / F ☐ Date of Hire: _____
City/State/Zip Code: _____ Years in Occupation: _____
Contact Number: _____

PROJECT INFORMATION:

Job Name: _____ Job #: _____
Job Address: _____ Time on job site: _____
Exact location of incident (Bldg/Level/Area): _____
Supervisor's Name: _____ Project Manager: _____

INJURY/ILLNESS INFORMATION:

Date of Incident: _____ Time of Incident: _____ am/pm Date Reported: _____
Body Part Affected: _____ Nature of Injury: _____ Time Reported: _____ am/pm
Description of Incident: _____
Investigation Conducted by: _____

MEDICAL FACILITY:

Treating Facility Address: _____ Phone #: _____
City/State/Zip Code: _____ Taken by whom? _____
Drug test performed? Y / N If no test performed, explain why? _____

EQUIPMENT INFORMATION:

Was equipment involved in the incident? ☐ Yes ☐ No If yes, please provide the following information:

Type of Equipment:		Serial Number:	
Model:		Owner of Equipment:	

Is a certification required to operate equipment? ☐ Yes (Provide a copy of certification) ☐ No

Note: In the event of a serious accident/incident, **NOTHING** shall be removed from the scene of the accident/incident until the investigation is completed.

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Employee Statement

Employee Name: _____ Job Number: _____
Title: _____ Trade: _____ Date of Incident: _____
Job Name: _____ Time of Incident: _____

1. Where were you when the incident occurred? _____

2. What activity were you performing at the time of the incident and what happened?

3. Name of witnesses and/or other employees working with injured worker:

Name	Email or Phone Number	Company

4. What Personal Protective Equipment (PPE) were you wearing at the time of the incident?

5. What do you think could have been done to prevent this type of incident from occurring?

Employee's Signature: _____ Date: _____

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Witness Statement

Witness Name: _____	Job Number: _____
Title: _____ Trade: _____	Job Name: _____
Home Address: _____	Date of Incident: _____
Phone #: _____	Time of Incident: _____
Employer Name: _____	
Employer Phone #: _____	

1. Where were you when the incident occurred? _____
2. What activity were you performing at the time of the incident? _____
3. What activity was the injured employee performing? _____

WITNESS Statement:

Signed by witness: _____ **Date:** _____

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