

Incident Report Form

Basic first report of a work injury, illness or near miss. Fill in the same shift, facts only.

DATE OF INCIDENT	TIME	JOB / PROJECT	EXACT LOCATION ON SITE
PERSON INVOLVED	JOB TITLE / TRADE	EMPLOYER (COMPANY OR SUB)	TIME THEY STARTED WORK

Type of event (tick all that apply)

- | | | | |
|---|--|--|--|
| ☐ Injury | ☐ Illness | ☐ Near miss (no one hurt) | ☐ Property damage |
| ☐ Vehicle or equipment | ☐ Fire or explosion | ☐ Spill or release | ☐ Other: |

WHAT WAS THE PERSON DOING JUST BEFORE IT HAPPENED? NAME THE TASK, TOOLS, EQUIPMENT AND MATERIALS

WHAT HAPPENED? DESCRIBE IT IN ORDER: WHAT MOVED, FELL, BROKE OR CONTACTED THE PERSON. FACTS ONLY, NO BLAME

INJURY OR ILLNESS (CUT, STRAIN, BURN, OTHER)	BODY PART(S) AFFECTED, LEFT OR RIGHT	OBJECT OR SUBSTANCE INVOLVED
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Treatment and outcome (tick all that apply)

- | | | |
|--|--|--|
| ☐ No treatment needed | ☐ First aid on site | ☐ Clinic or doctor visit |
| ☐ Emergency room | ☐ Admitted to hospital (in-patient) | ☐ Amputation or loss of an eye |
| ☐ Death | ☐ Sent home or off work after today | ☐ Light duty or restricted work |

FIRST AID GIVEN BY	TREATED AT (CLINIC OR HOSPITAL NAME)	PPE WORN AT THE TIME
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Witnesses

Name (print)	Company / trade	Phone	Statement taken?

IMMEDIATE ACTIONS TAKEN (AREA MADE SAFE, EQUIPMENT TAGGED OUT, PHOTOS TAKEN, HAZARD FIXED OR BARRICADED)

SUPERVISOR TOLD (NAME, DATE, TIME)	OSHA TOLD, IF REQUIRED (DATE, TIME, HOW)
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Death on the job: report to OSHA within 8 hours. Admitted to hospital as an in-patient, an amputation, or an eye lost: within 24 hours. Call 1-800-321-6742, call the nearest OSHA Area Office, or report online at [osha.gov](https://www.osha.gov) (29 CFR 1904.39).

COMPLETED BY (NAME, TITLE)	SIGNATURE	PHONE	DATE
PERSON INVOLVED: SIGNATURE	DATE	SUPERVISOR: SIGNATURE	DATE