Gregori Construction Inc.

Date: ____ /____/____
Time: ____:_____ AM / PM
Investigator's Initials: _____

Incident Investigation Form

All Sections Must be filled out. Be as Specific as possible and include drawings, photos and additional narrative as needed.	**Date Of Incident:**	**Job Location:**	**Time of Incident:** ___:___ AM/ PM

SECTION 1: EMPLOYEE INFORMATION

Employee Name:	Employee Title:
Employees Contact Information:	
Name and address of treating Physician (if applicable):	
Address / Job Location where the Incident Occurred (Be Specific):	

Incident Description: ☐ **Employee Injury** ☐ **Contractor Injury** ☐ **Non-Employee Incident**
☐ **Report Only** ☐ **Near Miss** ☐ **Vehicle**

SECTION 2: SUPERVISOR INFORMATION

Supervisor Name:	Supervisor Title:
Supervisor's Contact Information:	**Supervisor's Statement Attached?** ☐ **Yes** ☐ **No**

Time Supervisor Notified: : ☐ AM ☐ PM	Date Supervisor Notified:	Who reported the injury:

SECTION 3: WITNESS INFORMATION

Witnesses (List all names and Contact information):	**Witnesses Statement Attached?** ☐ **Yes** ☐ **No**

SECTION 4: INCIDENT INFORMATION

Property Damage: ☐ **Yes** ☐ **No** Vehicle Damage: ☐ **Yes** ☐ **No**

Drug Test Performed: ☐ **Yes** ☐ **No** If a Drug Test was not performed, Explain:

Was the workforce notified? ☐ **Yes** ☐ **No** If so Who Did you Speak to:

Initial Incident Description:

Location Conditions:

Weather Conditions:

Lighting Conditions:

Description of Enviromental Conditions:

Gregori Construction Inc.

Date: ____ /____/____
Time: ____:_____ **AM / PM**
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Incident Investigation Form

SECTION 5: INCIDENTS RESULTING IN INJURIES ONLY

Date Reported of Injury / Onset of Illness: _____ Did the injury occur on Gregori premises? : ☐ Yes ☐ No

Consequences of Injury/Illness:

OSHA 301
Selecting a value other than None of the Above or First Aid will result this incident as OSHA Recordable.

- ☐ Death
- ☐ Missed a day of work or next shift
- ☐ Restriction of work or transfer to another job
- ☐ Medical treatment beyond first aid
- ☐ Loss of consciousness
- ☐ Occupational illness
- ☐ First Aid
- ☐ None of the Above

Was the Authorization for Release of Medical Information completed? ☐ Yes ☐ No

Was the Employee Accident Statement completed? ☐ Yes ☐No **(Must Be included with Report)**

Was Medical Treatment Received? ☐Yes ☐ No

If Refused, Why? Medical Refusal Form MUST be attached:

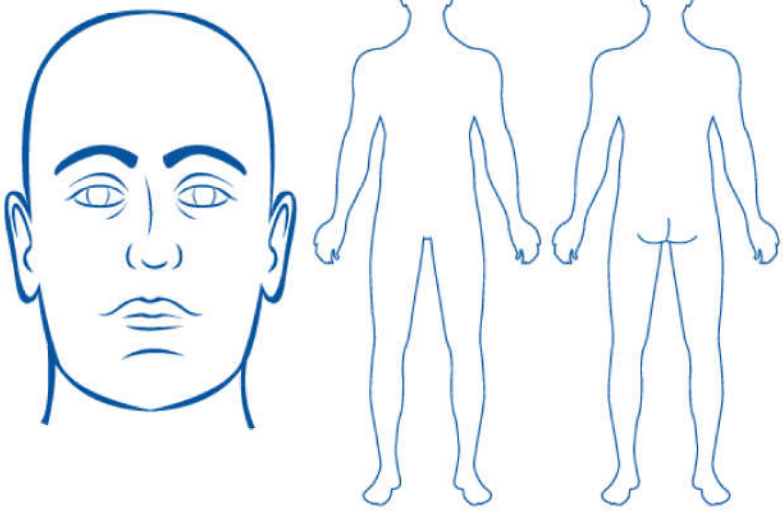
Initial Treatment of Injury / Illness:

Area of the body / body part affected:

PHOTOS MUST BE ATTACHED

Circle Affected Areas:

Front Back



Side of Body Affected:

- ☐ Left
- ☐ Right
- ☐ N/A

Additional Notes:

Gregori Construction Inc.

Date: ____ /____/____
Time: ____:_____ **AM / PM**
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Incident Investigation Form

Nature of Injury/Illness:

☐ Amputation	☐ Fainting	☐ Poisoning
☐ Asphyxiation	☐ Fracture	☐ Puncture
☐ Burn	☐ Freezing	☐ Radiation
☐ Carpal Tunnel Syndrome	☐ Hearing Loss/Impairment	☐ Respiratory Disorder
☐ Concussion	☐ Heat Prostration	☐ Rupture
☐ Contusion/Bruise	☐ Hernia	☐ Severance
☐ Crushing	☐ Infection	☐ Silicosis
☐ Dermatitis	☐ Inflammation	☐ Strain/Sprain
☐ Dislocation	☐ Laceration	☐ Tear
☐ Electric Shock	☐ Occupational Illness	☐ Vision Loss

Primary Cause of Injury/Illness:

☐ Burn/Scald – Heat or Cold Exposures – Contact With	☐ Motor Vehicle
☐ Caught in, Under, or Between	☐ Rubbed or Abraded By
☐ Cut, Puncture, Scape Injured By	☐ Strain or Injury By
☐ Fall, Slip, or Trip Injury	☐ Striking Against or Stepping On
☐ Miscellaneous Causes	☐ Struck or Injured By

Detailed Cause of Injury/Illness:

☐ Continual Noise	☐ Reaching
☐ Holding or Carrying	☐ Repetitive Motion
☐ Jumping or Leaping	☐ Twisting
☐ Lifting	☐ Using Tools or Machinery
☐ Pushing or Pulling	☐ Welding or Throwing
☐ Other	

SECTION 6: INCIDENTS INVOLVING MEDICAL TREATMENT ONLY

Was medical treatment given away from the worksite? ☐ Yes ☐ No

Was the employee treated in an emergency room? ☐ Yes ☐ No

Name of Physician or Other Health Care Professional:
Medical Facility Name:
Street Address:
City: State: Zip/Postal Code:
Phone:

SECTION 7: EMPLOYEE WORK BEHAVIOR

Time Employee Began Work: : ☐ AM ☐ PM	Time Employee Ended Work: : ☐ AM ☐ PM
Was an alleged unsafe or defective tool involved? ☐ Yes ☐No	If yes, has necessary documentation been completed? ☐Yes ☐ No

Were safety rules and safe work practices being followed? ☐ Yes ☐ No
If No, Please Explain:

Did the employee's actions contribute to the alleged injury? ☐ Yes ☐ No
If Yes, Explain:

Gregori Construction Inc.

Date: ____ /____/____
Time: ____:_____ **AM / PM**
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Incident Investigation Form

SECTION 8: ROOT CAUSE ANALYSIS (What was the root cause of the incident, i.e what actually caused the incident)

Unsafe Acts
- ☐ Improper Work Technique
- ☐ Improper PPE, Not Used or Used Incorrectly
- ☐ Safety Rule Violation
- ☐ Operating Without Authorization
- ☐ Failure to Warn or Secure
- ☐ Operating at Improper Speeds
- ☐ By-Passing Safety Devices
- ☐ Guards Not Used
- ☐ Improper Loading or Placement
- ☐ Improper Lifting
- ☐ Servicing or Adjusting Machinery in Motion
- ☐ Horseplay
- ☐ Unsafe Act(s) of Others
- ☐ Other:

Unsafe Conditions
- ☐ Poor Workstation Design or Layout
- ☐ Congested Work Area
- ☐ Hazardous Substances
- ☐ Inadequate Ventilation
- ☐ Improper Material Storage
- ☐ Improper Tool or Equipment
- ☐ Insufficient Job Knowledge
- ☐ Slippery Conditions
- ☐ Poor Housekeeping
- ☐ Inadequate Guarding of Hazards
- ☐ Defective Tools/Equipment
- ☐ Insufficient Lighting
- ☐ Inadequate Fall Protection
- ☐ Other:

Management System Deficiencies
- ☐ Lack of Written Procedures or Safety Rules
- ☐ Safety Rules Not Enforced
- ☐ Hazards Not Identified
- ☐ PPE Unavailable
- ☐ Insufficient Worker Training
- ☐ Insufficient Supervisor Training
- ☐ Improper Maintenance
- ☐ Inadequate Supervision
- ☐ Insufficient Job Planning
- ☐ Poor Process Design
- ☐ Inadequate Equipment
- ☐ Unsafe Design or Construction
- ☐ Other:

List immediate actions taken and results:

What should be done to prevent a recurrence: (Be specific as to what would prevent the injury, incident or damage from occurring again)

SECTION 9: JOB SAFETY ANALYSIS REVIEW

Is there a FDSP/JSA that applies to the task being performed when the injury or incident occurred? ☐ Yes ☐ No
If yes, review the FDSP/JSA, answer the following questions, and attach a copy to this report.
If no, please explain why the FDSP/JSA was not required for the task.

Were hazards sufficiently identified? If not, please explain. ☐ Yes ☐ No

Were identified controls adequate and implemented? If not, please explain. ☐ Yes ☐ No

Is a copy of the FDSP/JSA attached? If not, please explain? ☐ Yes ☐ No

SECTION 10: CORRECTIVE ACTIONS

List action(s) that have or will be taken to Prevent a recurrence.	Assigned To Whom	Scheduled Completion Date	Actual Completion Date	Follow-up Date

SECTION 11: INVESTIGATION TEAM

Lead Investigator Name:	Lead Investigator Title:	
Time of Report: : ☐ AM ☐ PM	Date Notified Safety Management:	Time Notified Safety Management: : ☐ AM ☐ PM
Was Customer Notified? If No, Explain: ☐ Yes ☐ No	Whom did you notify?	

Gregori Construction Inc.

Date: ____ /____/____
Time: ____:_____ **AM / PM**
Investigator's Initials: _____

Incident Investigation Form

SECTION 12: VEHICLE / EQUIPMENT INCIDENTS ONLY

Employee Operated Vehicle Equipment: | **PHOTOS MUST BE INCLUDED**

Vehicle Type: ☐ Company ☐ Private

Vehicle/Equipment Make:	Vehicle/Equipment Model:	Vehicle/Equipment Year:	License Plate Number:

Vehicle Action:

- ☐ Backing
- ☐ Changing lanes or merging
- ☐ Going straight
- ☐ Maneuvering to avoid an object
- ☐ Negotiating a curve
- ☐ Parked
- ☐ Standing/Stopped
- ☐ Stopping/Starting
- ☐ Turning Left
- ☐ Turning Right
- ☐ Other (specify)_____

SECTION 12.1: DRIVER INFORMATION

Employee Name: | Employee Title:

Employee Home Address:

Was an Employee Statement taken? **MUST** be attached with report. ☐ Yes ☐ No
If No, Explain:

Employee Driver's License Number: | Issuing State:

Does Employee Hold a Valid Driver's License for Vehicle/Equipment Being Operated: ☐ Yes ☐ No

Employee Drivers Record: ☐ Clean/No Violations ☐ Violations | Do we have a current Driver History Report on File: ☐ Yes ☐ No

SECTION 12.2: PASSENGER INFORMATION

Number of Passenger(s):

Passenger Name (Use additional lines if necessary):

Passenger Home Address:

Damage to Vehicle:

OTHER VEHICLES:

How many other vehicles were involved in the incident?

Vehicle/Equipment Make: | Vehicle/Equipment Model:

Vehicle/Equipment Year: | License Plate Number:

Was insurance information gathered on all additional vehicles? If not, Explain: ☐ Yes ☐ No

SECTION 12.3: INSURANCE INFORMATION

Company: | Policy Number:

SECTION 12.4: EMERGENCY RESPONDERS

☐ Fire/Emergency Medical Services — Fire/Medical Report #_____

☐ Police/Security — Police Report # _____

If any of these boxes are checked, a copy of the Official Report must be included.

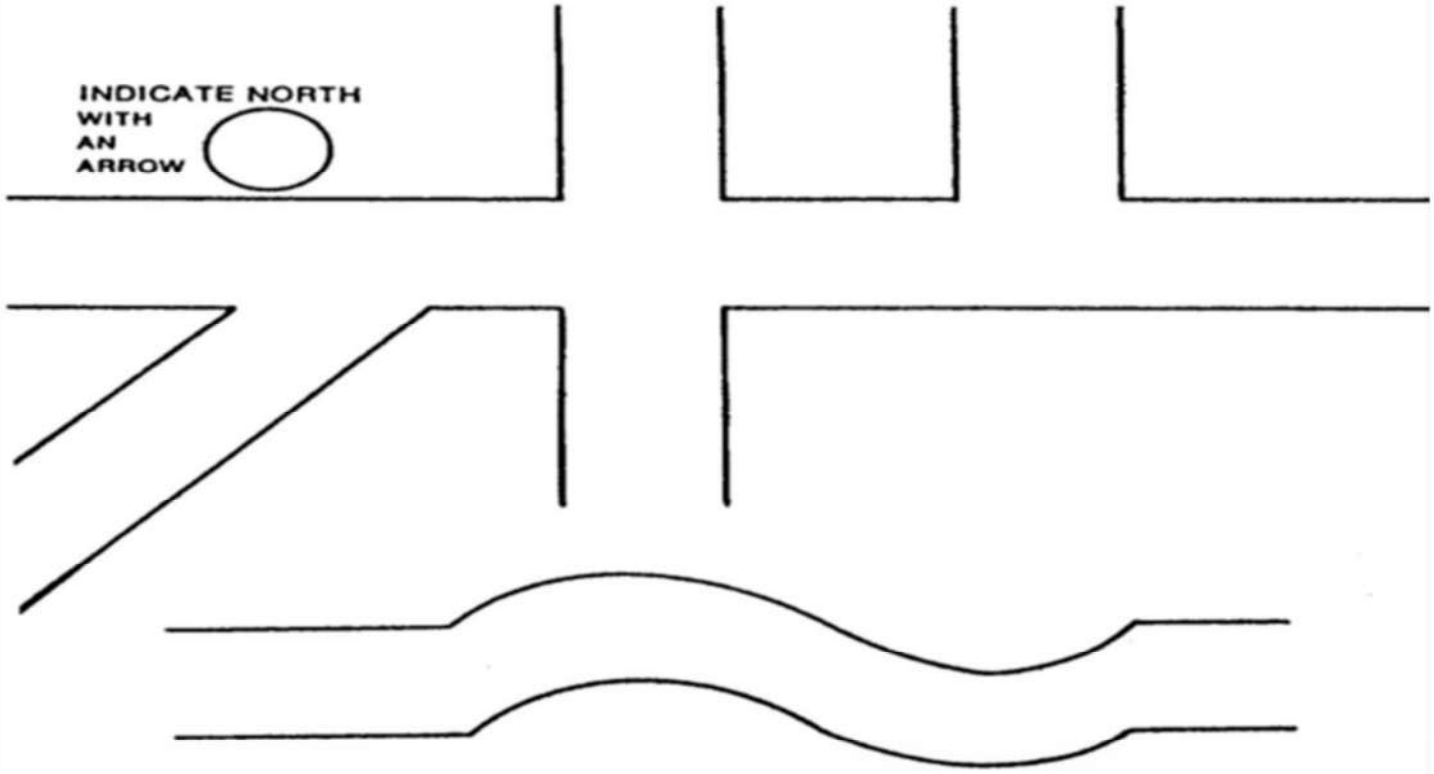
Gregori Construction Inc.

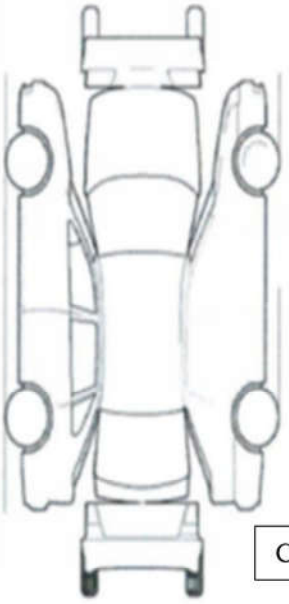
Date: ____ /____/____
Time: ____:_____ **AM / PM**
Investigator's Initials: _____

Incident Investigation Form

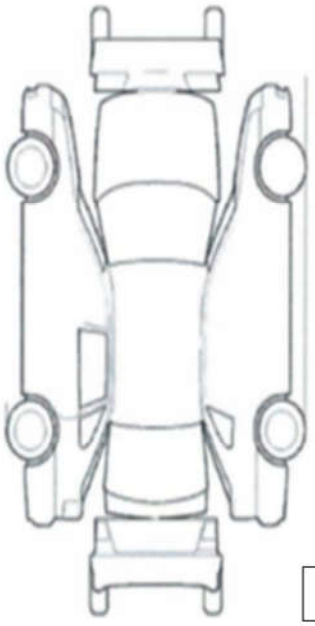
SECTION 12.5: ACCIDENT DIAGRAM

Sketch a diagram below showing exact relationship of roadways and vehicles at the time of the accident. (Indicate North) Show measurements if possible. (Identify your vehicle as #1, other vehicles as #2, #3, etc.)





Company Vehicle



Passenger Vehicle

Gregori Construction Inc.

Date: ____ /____/____
Time: ____:_____ AM / PM
Investigator's Initials: _____

Incident Investigation Form

SECTION 12.6: PROPERTY DAMAGE
Location of Damage:
Type of Damage:
Estimated Cost of Damage:
PHOTOS OF DAMAGE MUST BE INCLUDED
Was Damage caused by Employee Carelessness? ☐ Yes ☐ No
Were Precautions taken to avoid damages? ☐ Yes ☐ No
Was damage caused by faulty or defected equipment? ☐ Yes ☐ No
Did damage occur to public utility? ☐ Yes ☐ No
Additional Comments/ Notes: