SUPERVISOR INCIDENT REPORT

Preliminary Report must be completed and submitted to the Safety Department within 24 **hours** of the Incident.
Final Report must be completed and submitted with all attachments within **5 business days** of the incident.

Fax: (301) 595-2839 Email: safety@freestateelectric.com

CHECK ONE:

[ ] **Information Only** [ ] **Preliminary Report**
[ ] **Near Miss** [ ] **Final Report**

Type of incident - circle all that apply:

Injury **Auto Liability** **General Liability** **Property Loss** **Equipment Damage**

Today's Date: ___________ Date of incident: ________ Date of Report: ____________

Report Completed by: ____ Cell #: ______________
Please Print

Complete Section 1 and all other sections that apply.

1. INCIDENT

Date of incident: ______ Time: _____ AM PM Weather: ______________________ Road Conditions: ______________

Job Name/Number: ____

Project Address: ____

Project Manager: _________________________________ Project Engineer: _________________________________

Superintendent: _________________________________ Foreman: ____

Injured Employee Name, if applicable: (Compete section 2) ____

Crew Members: ____

____

Location of incident: ____

Witnesses: (see section 7, Witness Statement Form)

____

____

Police Notified: Yes [ ] No [ ] N/A [ ] Police Report Filed: Yes [ ] No [ ] N/A [ ]

Jurisdiction: _____________________________________ Phone #: __________________________
Officer Name: ____________________________________ Officer Badge #: ___________________________

Post-Accident Drug Test completed: Yes [ ] No [ ] If yes, date of test: ____________ If no, explain below:

____

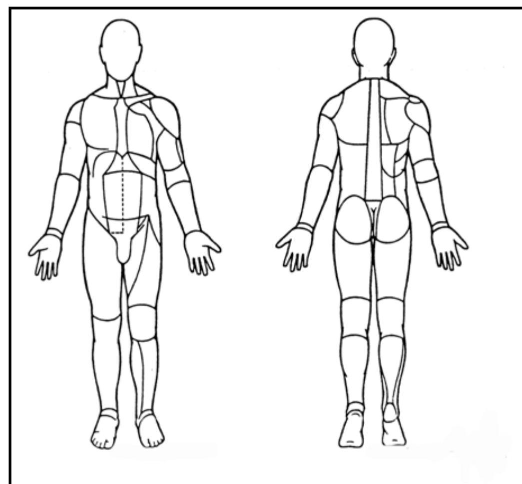
2. EMPLOYEE INJURY OR ILLNESS

Employee Name: ____ Phone number: _____________

Employee Home Address: ____

Job Class: _________________ Date of Hire: _______________

Body part affected: ____________________________________



Shade specific body part(s) injure**d**

Object/equipment/substance inflicting injury or illness: ____

Person with most control of object/equipment/substance : ____

Did the injured employee leave work? Yes [ ] No [ ]

Employee wearing : [ ] hard hat [ ] safety glasses [ ] goggles [ ] steel toe boots [ ] gloves [ ] other

Description of injury: ____

____

____

____

____

____

MEDICAL TREATMENT:

Dr. Blink Notified: Yes [ ] No [ ] . If yes, instructions: ____

____

Check One: [ ] No medical treatment necessary

[ ] Minor treatment/ First aid on site only:

First Aid administered by: ____

[ ] Minor treatment/First Aid - Clinic or hospital

Facility: ____

Physician: ____

[ ] Emergency Room evaluation

Facility: ____

Physician name: ____

5. DESCRIPTION OF INCIDENT - To be completed tor all incidents.

Describe in detail the circumstances of the incident. Give a chronological sequence of events. If materials, equipment and/or vehicles were involved, start before they were brought to the incident scene and describe the who, what, where when, and how the incident happened in your words below (specifically detail who, what, where, when, how, and why you believe the incident happened):

DIAGRAM OF INCIDENT - To be completed tor all incidents.

Show position and any relative distances of employee(s), vehicle(s), equipment, pedestrians, property, etc., and indicate an arrow of direction for each if travel or moving equipment was involved.

6. *LESSONS LEARNED - To be completed for all incidents.

Attach copies of the Job Hazard Analysis, PTP, Permits, or any other documents pertinent to this incident.

1. Did the **Job Hazard Analysis** and/or **PTP** discuss the potential for this incident? [ ] Yes [ ] No
2. Were safe work procedures developed to prevent an incident of this kind? [ ] Yes [ ] No
3. Were the safe work procedures followed? [ ] Yes [ ] No
4. What was the root cause of the incident? (weather, lighting, traffic control plan, poor communication, etc.). Explain in detail.

5. What Corrective Action was taken to prevent recurrence?

*May be augmented with Root Cause Analysis (See Policy)

<table>
<tr><td colspan="4">DATE OF INCIDENT ANALYSIS:</td></tr>
<tr><td colspan="2">PARTICIPANTS IN INCIDENT ANALYSIS</td><td>MANAGEMENT REVIEW</td><td>DATE</td></tr>
<tr><td>NAME</td><td>JOB CLASS</td><td rowspan="2">General Manager/Operations Manager</td><td rowspan="2"></td></tr>
<tr><td></td><td></td></tr>
<tr><td></td><td></td><td rowspan="2">Project Manager</td><td rowspan="2"></td></tr>
<tr><td></td><td></td></tr>
<tr><td></td><td></td><td rowspan="2">Project Engineer</td><td rowspan="2"></td></tr>
<tr><td></td><td></td></tr>
<tr><td></td><td></td><td rowspan="2">Superintendent</td><td rowspan="2"></td></tr>
<tr><td></td><td></td></tr>
<tr><td></td><td></td><td rowspan="2">Foreman</td><td rowspan="2"></td></tr>
<tr><td></td><td></td></tr>
<tr><td></td><td></td><td rowspan="2">Safety Representative</td><td rowspan="2"></td></tr>
<tr><td></td><td></td></tr>
</table>

7. EMPLOYEE AND WITNESS STATEMENT FORM

PLEASE PRINT

Witness Name: ______________________________ Phone #: ______________________

Witness Address: ____

Witness Employer: ____________________________ Employer Phone #: __________________

Date and time of incident: ______________________________ am / pm

Supervisor notified – date and time: ________________________ am / pm

THIS IS WHAT HAPPENED:

Who: ____

____

What: ____

____

____

____

____

____

____

____

When: ____

____

How: ____

____

Why: ____

____

____

____

Do you recall anything unusual or unexpected that happened? [ ] Yes [ ] No If yes, explain below. Use additional pages if necessary.11

____

____

____

____

____

____

____

Witness Signature: ____ Date: ____________

Company Representative initiating witness report - Print Name: ___________________________

Company Representative – signature: