



INCIDENT REPORT

1R 101-1

SECTION 1 - TO BE COMPLETED BY WORKER	
INCIDENT INFORMATION	INCIDENT CLASSIFICATION
Is this an injury incident? YES NO <i>(if Yes, complete form IR 101-2, 101-3)</i>	<input type="checkbox"/> PROPERTY DAMAGE <input type="checkbox"/> EQUIPMENT DAMAGE <input type="checkbox"/> INJURED WORKER <input type="checkbox"/> NEAR MISS <input type="checkbox"/> MOTOR VEHICLE ACCIDENT <input type="checkbox"/> ENVIRONMENTAL (SPILL) <input type="checkbox"/> FIRE / EXPLOSION <input type="checkbox"/> VIOLENCE <input type="checkbox"/> OCCUPATIONAL ILLNESS <input type="checkbox"/> SECURITY / THEFT <input type="checkbox"/> OTHER _____
Date and Time of Incident: (mm/dd/yyyy) Time: AM/PM	
Date Incident Reported: (mm/dd/yyyy)	
Name of Person Reporting Incident:	
Contact # of Person Reporting Incident:	
Name of Supervisor Reporting to:	
Supervisors Contact #:	
Names of ALL Workers / Witnesses on-Site at Time of Incident:	
*Witnesses to Complete Form # IR-101-9	
1)	
2)	
3)	
4)	
If this is an injury incident, and this form is completed by someone other than the injured, indicate here whom is reporting on behalf of injured person. Name:	
Physical Location / Address of Incident:	
Weather Conditions at time of Incident: Temp: Wind:	
Did incident occur on Client's jobsite or property YES NO Was Client Notified? YES NO	
Client Name:	
Client Representative: Client Rep Phone #:	
DETAILED DESCRIPTION OF INCIDENT	
PHOTOS: Take photo of all angles of incident site before distributing the scene. Email photos to:	



INCIDENT CAUSE FORM

INCIDENT DATE:			
CONTACT & IMMEDIATE CAUSES			
CONTACT / EXPOSURE	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Struck against Struck by Caught in Caught between Caught on Contact with Other:	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
SUBSTANDARD (UNSAFE) PRACTICES	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Operating equipment without authority Improper placement Failure to warn Safety devices inoperable Horseplay Improper loading Removing safety devices Improper position for task Poor control of Contractor Excessive Force	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
SUBSTANDARD (UNSAFE) CONDITIONS	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Inadequate guards or barriers Inadequate/improper protection equip Slippery surface Noise exposure Defective tools, equip or mat Temperature extremes Inadequate ventilation Congestion or restricted action Other:	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
BASIC CAUSES			
PERSONAL FACTORS		JOB / SYSTEM FACTORS	
<input type="checkbox"/> <input type="checkbox"/>	Lack of knowledge / skills Lack of coaching Inadequate orientation Inadequate training Inadequate instructions Lack of experience Stress Fatigue Substance abuse Excessive frustration Lack of supervisor reinforcement / incentive Short-cutting / Attempt to save time Other:	<input type="checkbox"/> <input type="checkbox"/>	Conflicting goals, objectives or standards Inadequate tools, equipment & materials Inadequate maintenance Inadequate leadership / supervision Inadequate instructions, orientations or training Inadequate work planning Unclear / conflicting roles and responsibilities Improper equipment provided for task Wear and tear Unclear organizational rules Inadequate engineering Abuse or misuse of equipment Other:



INJURY INCIDENT FORM

1R101-1

INCIDENT DATE:				
INJURY INCIDENT DETAILS				
Was First Aid administered on worker?	YES	NO	If yes: by Whom:	
Did worker seek immediate medical attention?	YES	NO	If yes; location:	
Did worker visit hospital, emergency room or physician?	YES	NO	If yes; please describe:	
Description of medical treatments:				
Description of medical recommendations:				
INJURY INCIDENT CLASSIFICATION: Please circle				
FIRST AID	MEDICAL AID	MODIFIED DUTIES	LOST TIME	FATALITY

INJURY DESCRIPTION				
TYPE OF INJURY			BODY PARTS AFFECTED	
<input type="checkbox"/> CUT	<input type="checkbox"/> HEAT BURN	<input type="checkbox"/> HEAD	<input type="checkbox"/> FINGER (specify which ones)	
<input type="checkbox"/> BRUISE	<input type="checkbox"/> CHEMICAL BURN	<input type="checkbox"/> FACE		
<input type="checkbox"/> ABRASION	<input type="checkbox"/> ELECTRICAL BURN	<input type="checkbox"/> EYES (L / R)	<input type="checkbox"/> LEG (L / R)	
<input type="checkbox"/> CRUSHING	<input type="checkbox"/> CONCUSSION	<input type="checkbox"/> BACK	<input type="checkbox"/> KNEE (L / R)	
<input type="checkbox"/> SPRAIN / STRAIN	<input type="checkbox"/> HEAT STROKE	<input type="checkbox"/> TRUNK	<input type="checkbox"/> ANKLE (L / R)	
<input type="checkbox"/> FRACTURE / BREAK	<input type="checkbox"/> FROST BITE	<input type="checkbox"/> ARMS (L / R)	<input type="checkbox"/> FOOT (L / R)	
<input type="checkbox"/> PUNCTURE	<input type="checkbox"/> AMPUTATION	<input type="checkbox"/> HAND (L / R)	<input type="checkbox"/> TOES	
<input type="checkbox"/> CHEMICAL EXPOSURE	<input type="checkbox"/> NOISE EXPOSURE	<input type="checkbox"/> OTHER:		

WCB / OHS REPORTING		
Has the injured worker missed more than 48 hours of work?	YES	NO
Did the employee stay in hospital overnight?	YES	NO
Has the WCB Employer report been filed online?	YES	NO
IF NOT FILED, ALERT MANAGEMENT IMMEDIATELY		



INVESTIGATION REPORT

1R 101-5

To be completed by Investigator / Supervisor

INFORMATION	
Investigated By: _____	Additional Team Members: _____
Date (mm/dd/yyyy) _____	_____
Signature: _____	

CAUSE
Immediate cause of incident:
Underlying causes of incident:
What training, orientation, documentation was given before the incident:

COMMENTS / CORRECTIVE ACTIONS		
COMMENTS		
CORRECTIVE ACTION (S)	PERSON RESPONSIBLE	TARGET DATE
_____	_____	_____
_____	_____	_____
_____	_____	_____

ENDORSEMENTS		
I ACCEPT ACCOUNTABILITY FOR IMPLEMENTING THE ITEMS OF THIS ACTION PLAN UNDER OUR RESPONSIBILITY		
General Manager: _____	Signature: _____	Date: _____



SPILL REPORT

1R 101-1

NAME OF CLIENT:		
Date & Time of Incident:	Date & Time Reported:	
Reported To:	Reported By:	
Type of Product?	Location of Spill:	
IS there a Toxic Odor?	Approximate Quantity:	
How did the Spill Occur?		
Is Spill On-Going?	YES NO Other	Is Spill Contained? YES NO Unknown
Incident Classification:	<input type="checkbox"/> Class 3 Minor (No significant adverse impact)	
	<input type="checkbox"/> Class 2 Serious (Causes or likely t	
	<input type="checkbox"/> Class 1 Major (Confined major impact)	
RESPONSE DETAILS	INVESTIGATIVE DETAILS	
Corrective Action Taken:	Cause of Spill:	
Government Agencies: (Please list)	Nature and Extent of Damages:	
Spill Control Services Involved:	Follow-up Required:	
Report Prepared By:		Date:
Manager's Signature:	Manager's Name: please print	Date:
Client Representative's Signature:	Client Rep's Name: please print	Date:



MOTOR VEHICLE ACCIDENT REPORT

1R 101-1

INCIDENT DATE:			
VCUG	Job #:	Location / Site:	
Time and Place of Event	Event Occurred at the Following Location: (Street, Highway Intersection etc.)		
	Hour _____	AM / PM _____	City: _____ Province: _____
VCUG Vehicle No. 1	Unit #:	Make, Year, Description:	Licence Plate and Province:
	MFRS or Serial #		Garaged at: (City, Province)
	Parts Damaged:		Est. Cost of Repairs \$\$
VCUG Driver	Driver's Name:		Alleged Injuries:
	Driver's Age:		
	Drivers Address: (home)		Telephone #:
Alleged Injured Persons	Full Name:		Alleged Injuries:
	Age:		
	Full Address:		Attended by: (where) (if Hospital, give name)
	Full Name:		Alleged Injuries:
	Age:		
	Full Address:		Attended by: (where) (if Hospital, give name)
Claimant's Vehicle No. 2	Name & Type of Car:	License No. & Prov.	Operated by: _____ Age: _____
	Owner of Vehicle No. 2	Telephone:	Operator License No. & Province
	Owner's Address:	Est. Repairs: \$	Parts Damaged:
Claimant's Vehicle No. 3	Name & Type of Car:	License No. & Prov.	Operated by: _____ Age: _____
	Owner of Vehicle No. 3	Telephone:	Operator License No. & Province
	Owner's Address:	Est. Repairs: \$	Parts Damaged:
Witnesses Important Include By-Standers and Other Disinterested Witnesses	Name:		Name:
	Address & Phone No.:		Address & Phone No.:
	Name:		Name:
	Address & Phone No.:		Address & Phone No.:
Police Activity	Officer's Name & Address:	Police File #	City or County <i>circle one</i>
	Was Citation Issued?:	To Whom and for What?	

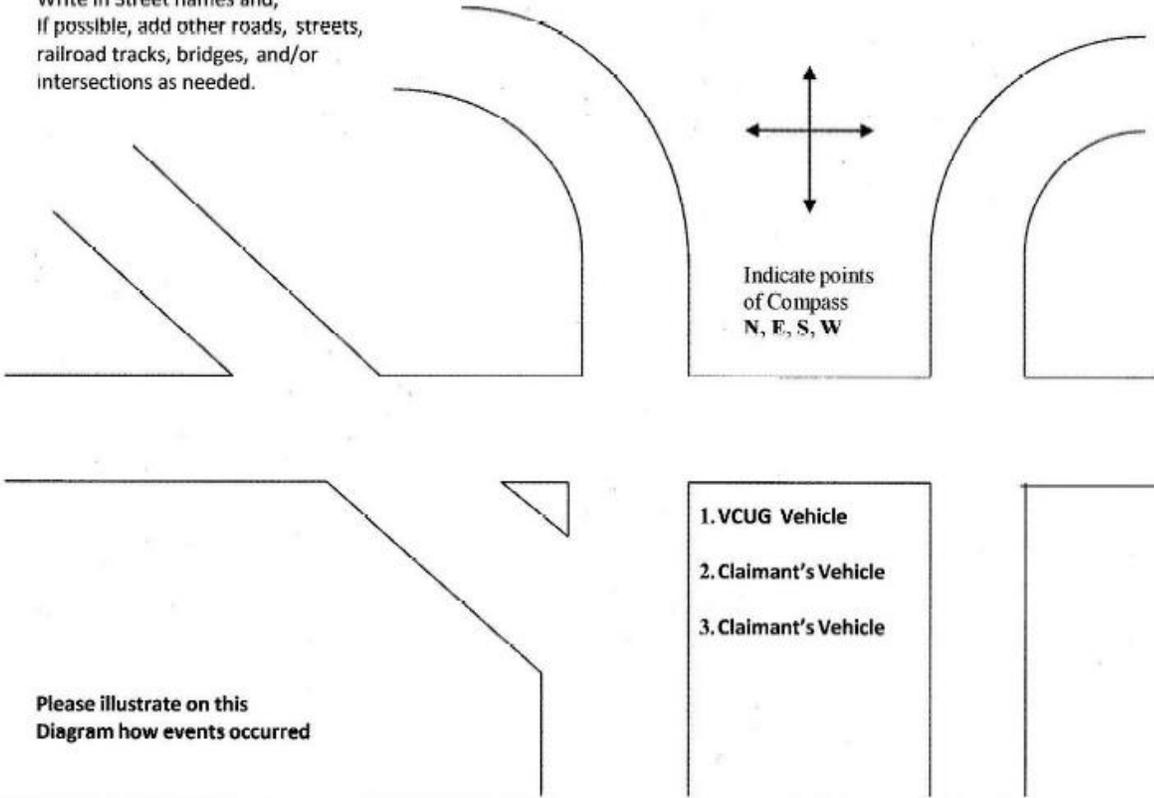


MOTOR VEHICLE ACCIDENT DETAILS

INCIDENT DATE:

Conditions at Time of Event	Direction of Your Vehicle	Est. Rate of Speed:	What Side of Street:	X	Street Construction	X	Other Conditions
	Direction of Vehicle No. 2:	Est. Rate of Speed:	What Side of Street:		Asphalt		Dry
	Direction of Vehicle No. 3:	Est. Rate of Speed:	What Side of Street:		Concrete		Wet
	Width of Street or Streets (R.O.W.):				Board Road		Ice
					Gravel		Snow

Write in Street names and, if possible, add other roads, streets, railroad tracks, bridges, and/or intersections as needed.



Driver's Brief Description of Event (Please Print) (Omit Any Conclusions as to Fault)

Did the Driver of the Other Vehicle Have Liability Insurance YES NO If Yes; complete next line

Name of Agent: _____ Address & Telephone No.: _____ Policy #: _____

Driver's Signature _____ Date: _____

Signature of Authorized Supervisor: _____ Date: _____

Please Check One:

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Light (L) Damage <\$1000	Serious (S) Damage >\$1000<\$10,000	Major (M) Damage Damage >\$10,000 < \$100,000	Catastrophic (XC) Damage >\$100,000

