Personal Injury & Incident Report

EMPLOYER INFORMATION

Report By: _____ **Title:** _____

Location of Incident: _____ **Federal ID #:** 23-2308981

Location Address: _____ **City, State & Zip:** _____

Contact Person: _____ **Phone #:** _____

EMPLOYEE INFORMATION

Name: _____ **Social Security #:** _____

Phone #: _____ **Date of Birth:** _____

Address: _____ **City, State & ZIP:** _____

Marital Status: ☐ Single ☐ Married ☐ Divorced **# of Dependents:** _____

Job Title: _____ **Date of Hire:** _____

☐ Full Time ☐ Part Time **Normal Hours Per Week:** _____

☐ Hourly ☐ Salaried **Rate of Pay:** _____

FACTS OF INCIDENT

Illness? ☐ Yes ☐ No

Injury? ☐ Yes ☐ No

Fatality? ☐ Yes ☐ No

Property Damage? ☐ Yes ☐ No

Did the Incident Occur on Employer's Premises? ☐ Yes ☐ No **If not, Where?** _____

What Area? _____ **Date of Incident:** _____

Time of Incident: _____

What was the employee doing when the incident occurred? (Be specific. What tools or equipment were being used? What material was the employee handling?)

Explain how the incident occurred. List events that resulted in injury, what happened, how it happened, and name objects and how they were involved.

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FACTS OF INCIDENT (continued)

Explain any and all lost time related to the incident. Date employee reported injury to the employer? First day of lost time. Anticipated return to work date. Was employee paid for full shift date of incident? Etc.

Is the alleged incident questionable? ☐ Yes ☐ No If Yes, explain in detail:

Was the employee doing his/her regular job?	**☐ Yes ☐ No**	**Was Employee wearing proper PPE?**	**☐ Yes ☐ No**
How long have they been doing this job?	**☐ Yes ☐ No**	**Was Employee properly trained?**	**☐ Yes ☐ No**
Were equipment/tools properly: Selected:	**☐ Yes ☐ No**	**Were environmental conditions a factor?**	**☐ Yes ☐ No**
Maintained:	**☐ Yes ☐ No**	**Visibility adequate?**	**☐ Yes ☐ No**
Used:	**☐ Yes ☐ No**	**Surfaces: dry, not slippery?**	**☐ Yes ☐ No**
Did the employee follow safety procedures?	**☐ Yes ☐ No**	**Housekeeping satisfactory?**	**☐ Yes ☐ No**

If you answered No to any above questions, please explain:

Describe the injury and indicate the part of the body affected (burn on left, middle finger; cut on palm of right hand, etc.)

Has any prior-related injury to affected area of the body occurred while working for AIS? ☐ Yes ☐ No When_____

Has any prior-related injury to affected area of the body occurred at Previous Companies? ☐ Yes ☐ No

Has any prior-related injury to affected area of the body occurred Outside of Work? ☐ Yes ☐ No

Supervisor's assessment of action to be taken, including preventive measures to ensure the incident does not happen again:

Please attach any witness statements to this form.

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MEDICAL INFORMATION

Doctor's Name: _____

Hospital/Clinic Name: _____

Address: _____

City, State & Zip: _____

Phone #: _____

Fax #: _____

Treatment Given: _____

Work Restrictions: ☐ Yes ☐ No

Explain: _____

Work Ability Form Attached: ☐ Yes ☐ No

ADDITIONAL INFORMATION

Has the A.I.S. Safety Department been notified? ☐ Yes ☐ No

Date of Notification: _____

Has the cause of the incident been corrected? ☐ Yes ☐ No

Date of Corrections: _____

Explain Corrections: _____

_____ _____ _____

Signature of person completing this form **Title** **Date**

_____ _____

Signature of Project Manager **Date**

_____ _____

Signature of Safety Manager/Coordinator **Date**