NICHOLSON

Incident & Injury Report

Instructions:

(1) Save this form to your computer before submitting. DO NOT over write the template form provided on NIC.
(2) All questions must be answered. If the question is not applicable mark the space "**NA**".
(3) Photographs are required for all accidents. The photographs should show the scene of the accident as well as damage that has occurred to property and personnel. Photographs of the injury are also beneficial if obtained. The photographs should be taken before the scene of the accident is disturbed. Photographs should be attached to the report.

☐ Injury ☐ Vehicle Accident ☐ Property Damage ☐ Near Miss

Date and Time of Incident:____________________
Project # and Name:____________________
Project Address: ____________________

____
City State Zip Code County
Site Telephone No.:__________ Site Fax No.:__________
Site Superintendent:__________ Project Manager:__________

Name of Injured:____________________
Address:____________________

____
City State Zip Code County
Telephone No.__________ Date of Birth:__________
Date of Hire:__________ ☐ Full Time ☐ Part Time ☐ Union
No. Days Worked/Week:______ No. Hours Worked/Week:______ Normal Days Off:______

Were individual(s) wearing appropriate/required PPE? ☐ Yes ☐ No
Was any property damaged? ☐ Yes ☐ No
If property was damaged, please identify the property and damage sustained (Please be specific)

____
____
____
____

Estimated Cost of Property Damage:____________________

Severity of Incident/injury (Check one):

☐ Basic First Aid ☐ Medical Treatment ☐ Hospitalization ☐ Fatality
Restrictions?____________________
Parts of the body affected (Specify right or left):____________________
Nature of Incident/Injury (Please check all that apply):

☐ Abrasions	☐ Chemical Burns	☐ Fractures	☐ Punctures
☐ Allergic Reaction	☐ Cold Exposure	☐ Frostbite	☐ Skin Irritation/Allergy
☐ Bites	☐ Concussion	☐ Heat Burns	☐ Sprain/Strain
☐ Blisters	☐ Dislocation	☐ Heat Exhaustion	☐ Toxic Fume Exposure
☐ Bruises	☐ Exposure	☐ Heatstroke	☐ Toxic Ingestion
☐ Burns	☐ Faint/dizziness	☐ Lacerations	☐ Other:

Date medical treatment was first received (if applicable):____________________
Medical Facility:____________________
Address:____________________

____
City State Zip Code County
Telephone No.:____________________
Attending Physician:__________ Physician Telephone No.__________

INCIDENT/INJURY DESCRIPTION

Fully describe the incident in detail. Give the sequence of events that describe what happened leading up to and including the incident. Fully identify personnel and equipment involved and their role(s) in the incident.

Any related near misses? Have any same or similar near misses occurred prior to this incident?

DIRECT CAUSE

The direct cause is that single factor which most directly led to the incident.

INDIRECT CAUSES
Indirect causes are those factors which contributed to, but did not directly initiate, the occurrence of the incident.

Were there any witnesses to the incident/injury? ☐ Yes ☐ No

If yes, please provide the following:

NAME	EMPLOYER	TELEPHONE NO.

Diagram/Sketch Block (or send photos)

NICHOLSON

ACTIONS TO PREVENT RECURRENCE (Completed by _________________ based upon root-cause investigation)			
Action Taken	By Whom	By When	Date Completed

Actions Completed:

Signed (Manager):___________________________________ Title:_________________________

Date:_________________________

☐ Feedback to employee involved
Date:_______________________

Employee:

_______________________________ _______________________________ ________________
Name (print) Name *(signature)* Telephone No.

Supervisor/Manager:

_______________________________ _______________________________ ________________
Name (print) Name *(signature)* Telephone No.

CONSENT FOR RELEASE
of
MEDICAL RECORDS

I, ______________________________________, hereby request that Nicholson Construction Co. (NCC) be permitted to obtain copies of all hospital and medical records pertinent to my work related incident that occurred on ____________________.
(mm/dd/yy)

I consent to NCC interviewing all doctors and other attendants involved in my care, relating to my examination, diagnosis, care, treatment and prognosis. I further consent to the release of my records to the extent necessary to determine the reasonableness and necessity of the care being rendered to me.

I am willing that a fax of this authorization be accepted with the same authority as the original:

____ __________________________
(Print Name) **Date**

____
(Signature)

FORWARD THIS REPORT TO CORPORATE HEALTH & SAFETY WITHIN 24 HOURS

Nicholson Construction Co.
12 McClane St.
Cuddy, PA 15031
ATTN: Safety Department
(412) 221-4500
(412) 221-3127 (Fax)

N
2
1
FOLSOM ST.
TRACE WIRE BOX
6" YELLOW HDPE GAS LINE
3/4" STEEL STUB
6" STEEL GAS LINE
4TH ST.