



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: _____		<input type="checkbox"/> Full Time	<input type="checkbox"/> Part Time <input type="checkbox"/> Union
No. Days Worked/Week: _____		No. Hours Worked/Week: _____ Normal Days Off: _____	
Were individual(s) wearing appropriate/required PPE?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
Was any property damaged?		<input type="checkbox"/> Yes	<input type="checkbox"/> 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):			
<input type="checkbox"/> Basic First Aid	<input type="checkbox"/> Medical Treatment	<input type="checkbox"/> Hospitalization	<input type="checkbox"/> Fatality
Restrictions? _____			
Parts of the body affected (Specify right or left): _____			
Nature of Incident/Injury (Please check all that apply):			
<input type="checkbox"/> Abrasions	<input type="checkbox"/> Chemical Burns	<input type="checkbox"/> Fractures	<input type="checkbox"/> Punctures
<input type="checkbox"/> Allergic Reaction	<input type="checkbox"/> Cold Exposure	<input type="checkbox"/> Frostbite	<input type="checkbox"/> Skin Irritation/Allergy
<input type="checkbox"/> Bites	<input type="checkbox"/> Concussion	<input type="checkbox"/> Heat Burns	<input type="checkbox"/> Sprain/Strain
<input type="checkbox"/> Blisters	<input type="checkbox"/> Dislocation	<input type="checkbox"/> Heat Exhaustion	<input type="checkbox"/> Toxic Fume Exposure
<input type="checkbox"/> Bruises	<input type="checkbox"/> Exposure	<input type="checkbox"/> Heatstroke	<input type="checkbox"/> Toxic Ingestion
<input type="checkbox"/> Burns	<input type="checkbox"/> Faint/dizziness	<input type="checkbox"/> Lacerations	<input type="checkbox"/> Other: _____
Date medical treatment was first received (if applicable): _____			
Medical Facility: _____			
Address: _____			
City	State	Zip Code	County
Telephone No.: _____			
Attending Physician: _____		Physician Telephone No. _____	



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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.



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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)



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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.



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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:

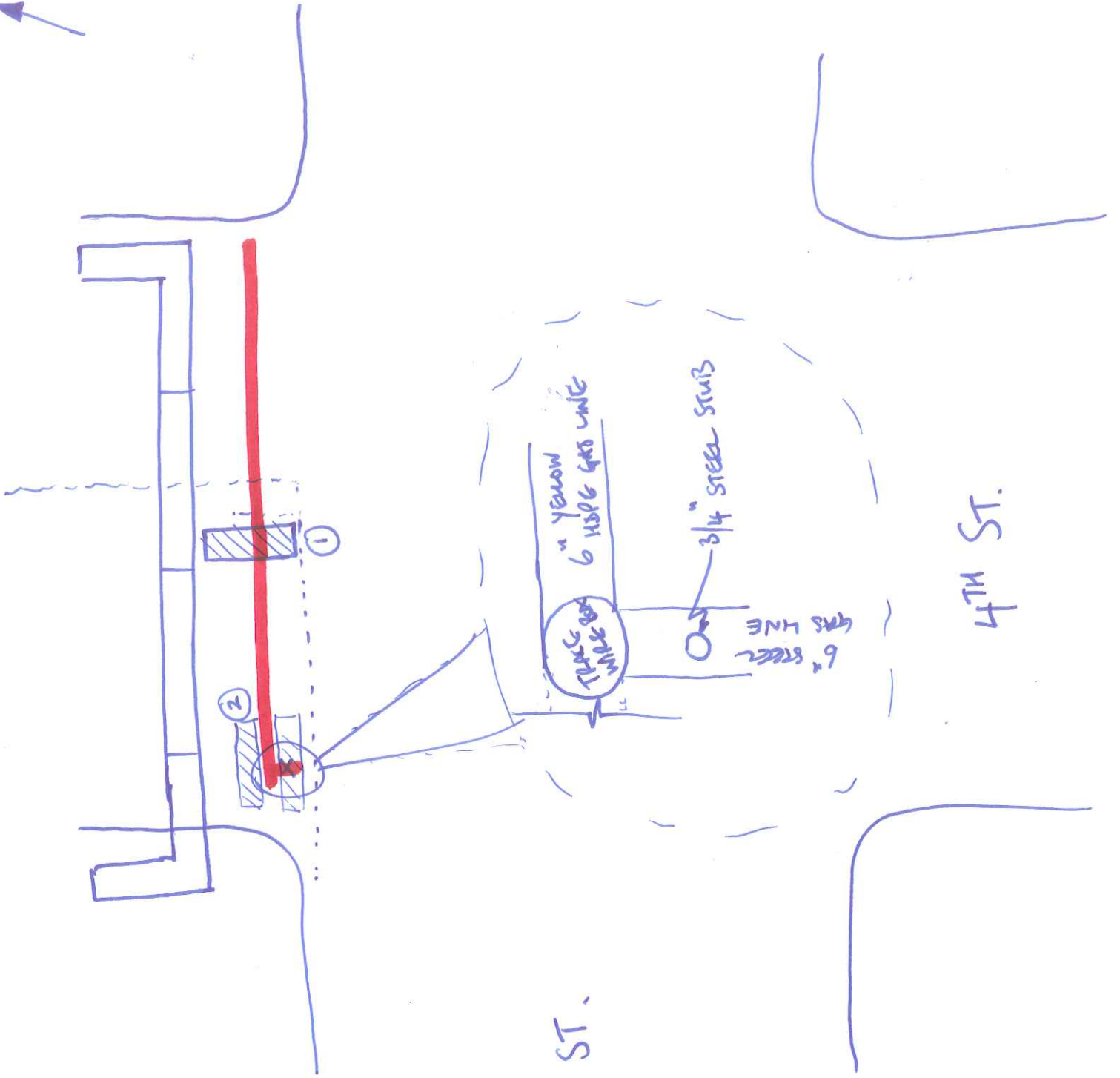
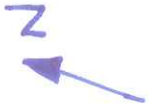
(Print Name)

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)



FOLSOM ST.

4TH ST.