**CONTRACTOR INCIDENT REPORT**

**Southern Ute Indian Tribe Growth Fund**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Vehicle** [ ]  | **Injury** [ ]  | **First Aid** [ ]  | **Property Loss** [ ]  | **Near Miss** [ ]  | **Environmental** [ ]  |
| **Contractor company name:** |       |
| **Date of report:** |       |

**1. EMPLOYEE INFORMATION:** (Enter all applicable information)

|  |  |  |  |
| --- | --- | --- | --- |
| Name of employee: |       | Employee I.D. #:  |       |
|  |  (First) | (Middle) |  (Last) |
| Employee’s home address:  |       | Phone #:  |       |
|  | (No. & Street)  | (City or Town) | (State) (Zip) |

**2. WORK INFORMATION:** (Enter all applicable information)

|  |  |  |  |
| --- | --- | --- | --- |
| Date of hire:  |       | Work location: |       |
|  |
| Job description:  |       |

**3. INCIDENT DESCRIPTION:** (Enter all applicable information)

|  |  |
| --- | --- |
| Exact location of accident:  |       |
|  |  (No. & Street) | (City or Town) |  (County) | (State) |  (Zip) |
| Date of incident:  |       | Time: |       | [ ] a.m.[ ] p.m. | Did accident occur on Company property?  | [ ]  Yes [ ]  No |
| Working shift From: |       | To:  |       | [ ] a.m.[ ] p.m. | How many hours had employee been on job?  |       |
|  |  |  |  |
| Date injury first reported to employer:  |       | Name of person notified:  |       |
|  |
| Describe the incident in detail; (if applicable indicate the part of the body and the side of the body affected) |  |
|       |
|  |
| What was the employee doing or what type of work was being conducted when the incident occurred?  |  |
|       |

|  |
| --- |
| How did the incident occur? (Describe all activity leading up to the accident. Tell what material, or tools were involved. Tell what happened just before, at the time of, and just after the accident.) |
|       |

|  |  |
| --- | --- |
| What machine tool, substance or object was most closely connected with the accident?  |  |
|       |

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| Did accident occur because of: | Intoxication | [ ]  Yes | [ ]  No | Failure to use safety devices | [ ]  Yes | [ ]  No |
| Failure to obey rules | [ ]  Yes | [ ]  No | Unsafe act by injured or others | [ ]  Yes | [ ]  No |
|  | Unsafe condition | [ ]  Yes | [ ]  No | Unsafe personal factors (attitude, etc.) | [ ]  Yes | [ ]  No |
|  | Was weather a factor? | [ ]  Yes | [ ]  No | If Yes, how? |       |
|  |  |
| What personal protective equipment is required for the job?  |       |
|       | Was it used? | [ ]  Yes | [ ]  No |
| What safety measures could the employer have taken to prevent the accident?  |
|       |
| Names and addresses of witnesses: |       |
|  |  (Name) |
|       |
|  (No. & Street) |  (City or Town) |  (State) |  (Zip) |

**4. MEDICAL TREATMENT INFORMATION:** (If applicable)

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Did employee receive medical attention? | [ ]  Yes | [ ]  No | Date of first medical care:  |       |
| Doctor’s office | [ ]  Yes | [ ]  No | Emergency room / clinic | [ ]  Yes | [ ]  No | Admitted to hospital?  | [ ]  Yes [ ]  No |
| Treatment provided: Medication: [ ]  Yes [ ]  No Stitches: [ ]  Yes [ ]  No Other: [ ]  Yes [ ]  No |
| If yes, please explain: |       |
| Names and addresses of medical provider: |       |
|  |  (Name) |
|       |       |       |       |
|  (No. & Street) |  (City or Town) |  (State) | (Zip) |
| Last date worked:  |       | Has employee returned to work?  | [ ]  Yes | [ ]  No | Date:  |       |
|  |  |  |  |  |  |  |
| If No, estimate number of days lost:  |       | Did injury / illness result in death?  | [ ]  Yes | [ ]  No | Date: |       |
|  |  |
| If death occurred, give name, age, relationship and address of known dependent: |       |
|  |  | (Name) |
|       |       |       |       |       |       |
| (Age) Relationship | (No. & Street) | (City or Town) | (State) | (Zip) |

**5. CONTRACTOR – SUPERVISOR’S INVESTIGATION:** (Must be completed prior to submitting for Inspection)

|  |  |
| --- | --- |
| What will you do to prevent recurrence of this type of accident?  |       |
|       |
|  |
| What has been done to prevent recurrence? |       |
|       |
|  |
| What were contributing causes of the accident? |       |
|       |
|  |

|  |  |
| --- | --- |
| When did you visit the accident site? |       |
|       |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Name:** |  | **Title:** |  | **Date:** |  |
|  |  |  |  |  (Supervisor or Foreman) |

**6. Company ONSITE INSPECTOR REVIEW:** (Must be completed prior to submitting to Company Safety Staff)

|  |  |  |
| --- | --- | --- |
| Do you agree with the results of this investigation?  | [ ]  Yes | [ ]  No |
|  |  |
| If No, please explain:  |       |
|  |
| What should be done to prevent recurrence?  |       |
|       |
|  |
| What will you do to prevent recurrence?  |       |
|       |
|  |
| When will action be completed?  |       |
|  |
| Name of Project Manager: |       |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Name:** |       | **Title:** |       | **Date Submitted:** |       |
|  |  |  |  |  (Company Representative) |

**7. Company SAFETY REVIEW:**

|  |  |  |
| --- | --- | --- |
| Do you agree with the results of this investigation?  | [ ]  Yes | [ ]  No |
|  |  |
| If No, is a Root Cause Investigation required?  | [ ]  Yes [ ]  No |  |
|  |
| When will Investigation be completed? |       |
|  |
| Investigation Facilitator: |       |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Name:** |  | **Title:** |  | **Date:** |  |
|  |  |  |  |  (Company Safety Rep.) |