

# HSE Incident Reporting Forms

IOGA of West Virginia

Rev 2 02 April 2003

**Pages Included in this report:**  General Information  Company Vehicle  Non Company Vehicle  Injury / Illness  Environmental  External Assessment  Witness / External Investigator or Adjuster  Property / Equipment Damage

## Section 1 General Information

### 1.1 Incident Type, Date and Time Information

<p><b>Incident Type</b> <i>Check any that apply</i></p> <p><input type="checkbox"/> Incident <span style="margin-left: 150px;"><input type="checkbox"/> Radiation Involved</span>  <input type="checkbox"/> Near Miss <span style="margin-left: 150px;"><input type="checkbox"/> Explosives Involved</span></p> <p><b>Primary Incident Type</b> <span style="margin-left: 100px;"><b>Secondary Incident Type(s)</b></span></p> <p><input type="checkbox"/> Injury Illness <span style="margin-left: 100px;"><input type="checkbox"/> Injury Illness</span>  <input type="checkbox"/> Vehicle <span style="margin-left: 100px;"><input type="checkbox"/> Environmental</span>  <input type="checkbox"/> Environmental <span style="margin-left: 100px;"><input type="checkbox"/> Property / Equip Damage</span>  <input type="checkbox"/> Property / Equip Damage <span style="margin-left: 100px;"><input type="checkbox"/> External Assessment</span>  <input type="checkbox"/> External Assessment</p> <p><b>Risk Assessment</b></p> <p><input type="checkbox"/> Risk Assessment Performed Prior to Incident?  <input type="checkbox"/> Was Risk Assessment Documented?</p>	<p><b>Date and Time Information</b></p> <p><i>Note: Date Format 01-JAN-99 Time Format 24 hr: 18:00</i></p> <table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 70%;"></td> <td style="width: 15%; text-align: center; border-bottom: 1px solid black;">Date</td> <td style="width: 15%; text-align: center; border-bottom: 1px solid black;">Time</td> </tr> <tr> <td>Occurrence Date and Time:</td> <td style="border: 1px solid black; width: 15%;"></td> <td style="border: 1px solid black; width: 15%;"></td> </tr> <tr> <td>Date and Time Reported:</td> <td style="border: 1px solid black; width: 15%;"></td> <td style="border: 1px solid black; width: 15%;"></td> </tr> <tr> <td>Incident Reported By:</td> <td colspan="2" style="border: 1px solid black; height: 20px;"></td> </tr> <tr> <td>Supervisor's Name in charge of work activity at time of incident:</td> <td colspan="2" style="border: 1px solid black; height: 20px;"></td> </tr> <tr> <td>Person Completing Form:</td> <td colspan="2" style="border: 1px solid black; height: 20px;"></td> </tr> <tr> <td>Person Completing Form Phone Number:</td> <td colspan="2" style="border: 1px solid black; height: 20px;"></td> </tr> </table>		Date	Time	Occurrence Date and Time:			Date and Time Reported:			Incident Reported By:			Supervisor's Name in charge of work activity at time of incident:			Person Completing Form:			Person Completing Form Phone Number:		
	Date	Time																				
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Person Completing Form:																						
Person Completing Form Phone Number:																						

### 1.2 Incident Location & Responsible Business Unit

<p><b>Occurrence Site</b> (describe where the incident occurred)</p>          	<p>Location Type:</p>          
Region:	
Country and State / Province (If U.S., include county)	

After Completing this form, distribute according to your local procedures

### 1.3 Description of Incident

**Brief Description:**

**Detailed Description**

## Section 2 Vehicle Incident Details

**Note:** Any vehicle where a company employee is driving, is considered a "company vehicle" If more than one company vehicle is involved, make copies of this page.

Check any that apply:

Company Vehicle Involved (Complete 2.1)

Non Company Vehicle Involved (Complete 2.2)

### 2.1 Company Vehicle Vehicle Information

Vehicle VIN	Vehicle Make
Company Number	Vehicle Model
License Number:	Vehicle Type
Vehicle a Rental? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Company: _____	

Driver License No. \_\_\_\_\_ State / Country \_\_\_\_\_

Expiry Date d/m/y \_\_\_\_\_ City, State Nearest the place where the incident occurred: \_\_\_\_\_

### Company or Non Company Driver and/or passenger information

Company Employee? Y/N	Last Name	First name	Emp. Number	Seat Belt Worn?
Driver:				<input type="checkbox"/> Yes <input type="checkbox"/> No
Passenger 1				<input type="checkbox"/> Yes <input type="checkbox"/> No
Passenger 2				<input type="checkbox"/> Yes <input type="checkbox"/> No
Passenger 3				<input type="checkbox"/> Yes <input type="checkbox"/> No
Passenger 4				<input type="checkbox"/> Yes <input type="checkbox"/> No
Passenger 5				<input type="checkbox"/> Yes <input type="checkbox"/> No

### Damage to Company Vehicle:

Recordability: <input type="checkbox"/> Company Reportable <input type="checkbox"/> Company Recordable <input type="checkbox"/> DOT Recordable (U.S. Only) <input type="checkbox"/> Documentation Only	
Vehicle weight more than 10,000 lbs (4550 kg)? <input type="checkbox"/> Yes Our Vehicle transporting Hazardous Material? <input type="checkbox"/> Yes Vehicle designed to transport 16 + passengers? <input type="checkbox"/> Yes Company Vehicle Towed From Scene? <input type="checkbox"/> Yes Non Company Veh Towed From Scene? <input type="checkbox"/> Yes	Hazardous Chemical Spilled? (other than fuel from the fuel tanks) <input type="checkbox"/> Yes Any party receive medical treatment away from the scene? <input type="checkbox"/> Yes Were there any fatalities? <input type="checkbox"/> Yes
Describe Damage to Company Vehicle:	

### Drugs & Alcohol Information

Was a drugs & alcohol test administered?	<input type="checkbox"/> No	<input type="checkbox"/> Yes - within 2 hours	<input type="checkbox"/> Yes - within 8 hours
<input type="checkbox"/> Yes within 32 hours (drugs only)			
If no drugs & alcohol test was administered, give details as to why not:			

After Completing this form, distribute according to your local procedures

## Section 2 Vehicle Incident Details - *Continued*

### 2.2 Non Company Vehicle *If more than one non-company vehicle was involved, make additional copies of this page.*

#### Vehicle Information

Vehicle VIN	Vehicle Make
License Number:	Vehicle Model
License Jurisdiction:	Vehicle Type
Non Company vehicle towed from scene? <input type="checkbox"/> Yes Medical treatment away from Scene? <input type="checkbox"/> Yes	Any indications of drugs and/or alcohol? <input type="checkbox"/> Yes

#### Non Company Vehicle - (Driver Information)

Last Name:	First Name:	
Address:		
Drivers License Information Number	State / Country	Expiry Date (01-JAN-99)
Insurance Company	Address and Phone Number	Policy Number

#### Injury details of non-company persons

Name:	Nature of Injury	Address / Phone Number
Name:	Nature of Injury	Address / Phone Number
Name:	Nature of Injury	Address / Phone Number

After Completing this form, distribute according to your local procedures

## Section 3 Injury / Illness Incident Details

Check all that apply

Company Employee (Complete 3.1)

Client Employee

Sub Contractor Employee

(Complete 3.2)

Member of Public (Complete 3.3)

Casual / Temporary / Contract Employee

### 3.1 Company Employee Details *For Additional Injuries associated with this incident, make copies of this page.*

**Recordability:** Check applicable recordability

- First Aid Case (Complete Justification)
- Non-Recordable Medical (Complete Justification)
- Restricted Work Case
- Lost Time Case
- Medical Case
- Fatality Case

- Non-Occupational Restricted Work Case
- Non-Occupational Lost Time Case
- Non-Occupational Medical Case
- Non-Occupational Fatality Case

#### Injured Party Information

Last Name:	First Name:	Emp. Number:
Job Task:	Job Activity:	
Body Part(s):	Nature of injury:	
Body Part(s):	Nature of injury:	
Additional Comments:		

#### Justification for "First Aid" or "Non Recordable Medical" Recordability Class

- Administering Tetanus Immunization
- Cleaning, Flushing or Soaking Wounds on the Surface of the Skin
- Drilling Fingernail / Toenail to Relieve Pressure or Draining Fluid from a Blister
- No Treatment Given (Diagnostic Only)
- Remove Foreign Bodies from the Eye using only Irrigation or Cotton Swab
- Remove Splinters / Foreign Material from Areas Other Than the Eye by Simple Means
- Use of Nonprescription Medication at Nonprescription Strength
- Use of Hot or Cold Therapy
- Using any Non Rigid Means of Support (i.e. Elastic Bandages)
- Using Finger Nail Guards
- Using Massages
- Using Wound Coverings such as Bandages, Gauze Pads or Butterfly Bandages

**Note:** In order to meet new US OSHA recordability requirements for 2002, this additional field has been added to the Incident database. This field MUST be completed for any incident occurring after the 31 December 2002, where the Recordability of Injury / Illness is listed as First Aid or Non Recordable Medical.

#### Drugs & Alcohol Information

Was a drugs & alcohol test administered?	<input type="checkbox"/> No	<input type="checkbox"/> Yes - within 2 hours	<input type="checkbox"/> Yes - within 8 hours
<input type="checkbox"/> Yes within 32 hours (drugs only)			
If no drugs & alcohol test was administered, give details as to why not:			

After Completing this form, distribute according to your local procedures

## Section 3 Injury / Illness Incident Details - Continued

### 3.2 Other Involved Parties

*Check applicable person type:* **Note: for additional parties, make copies of this page**  
 Sub Contractor Employee  Client Employee  Casual / Temporary / Contract Employee

#### Injured Party Information

Last Name:	First Name:	Company:
Phone	Address	
Job Task:	Job Activity:	
Insurance "Causes":		
Body Part(s):  <input type="checkbox"/> Left <input type="checkbox"/> Right	Nature of injury:	
Body Part(s):  <input type="checkbox"/> Left <input type="checkbox"/> Right	Nature of injury:	
Additional Comments:		

### 3.3 Member of Public Injured Party Details

Last Name:	First Name:	Task at time of incident:
Phone	Address	
Body Part(s):  <input type="checkbox"/> Left <input type="checkbox"/> Right	Nature of injury:	

After Completing this form, distribute according to your local procedures

## Section 4 Environmental Incident Details

Check all that apply:

Agent	Medium	Effect
<input type="checkbox"/> Substance <input type="checkbox"/> Explosion <input type="checkbox"/> Light <input type="checkbox"/> Noise <input type="checkbox"/> Radiation <input type="checkbox"/> Vibration	<input type="checkbox"/> Air <input type="checkbox"/> Ground Water <input type="checkbox"/> Soil <input type="checkbox"/> Surface Water	<input type="checkbox"/> People <input type="checkbox"/> Vegetation <input type="checkbox"/> Animals <input type="checkbox"/> Structures <input type="checkbox"/> Equipment <input type="checkbox"/> Materials

### Substance Information

Name of Substance ( Specify Material Name )	Amount	Unit of Measure

### Describe Response Details

## Section 5 External Assessment

***Check any that apply***

- |   |                                     |   |                                |
|---|-------------------------------------|---|--------------------------------|
| <input type="checkbox"/> Notice of Violation  | <input type="checkbox"/> Audit      | <input type="checkbox"/> Self Reported            | <input type="checkbox"/> Other |
| <input type="checkbox"/> Administrative Order | <input type="checkbox"/> Inspection | <input type="checkbox"/> Regulatory Investigation |                                |

**Describe the Assessment, If there are specific comments made by anyone, include those in Section 6, Witnesses / External Investigator or Adjuster.**

## Section 6 Witnesses / External Investigator or Adjuster

### Person 1

Last Name:	First Name:	Company:
Phone	Address	
Comments		

### Person 2

Last Name:	First Name:	Company:
Phone	Address	
Comments		

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After Completing this form, distribute according to your local procedures

## Section 7 Property / Equipment Damage

**Who Owns the Property / Equipment:**

- Company
- Client / Contractor
- Third Party

**Equipment type:**

*Examples: Tank, Building, Trailer, Fork Lift etc*

**Type of Damage**

- Structural     Mechanical     Process Failure     Theft     Sabotage     Fire
- Natural Causes (Earthquake, Flood, etc.)

**Description of Damage:**

*Provide details of the Type of Property and Equipment (with serial numbers etc., if applicable), and describe what happened and the extent of damage. If possible, provide an estimate of the cost of the damage.*