ACCIDENT NOTIFICATION REPORT

(Completed by foreman by end of shift)

PROJECT INFORMATION

Branch name (if any):	Branch (if any):
Job name:	Job number:
Job address:	
Job site contact:	Contact number:
Location where injury occurred: (e.g., 2nd floor, SE corner of building, etc.)	
OCIP/CCIP/PCIP? ☐ Yes ☐ No	

INJURED EMPLOYEE INFORMATION

Last name:	First name:	M.I.:
Address:		
Home phone number:	Best contact phone number:	
Date of birth:	Social Security number:	
Sex: M / F Martial status: S / M	Occupation/Trade:	
Employees' superintendent:	Phone:	
Employees' general foreman:	Phone:	
Employees' foreman:	Phone:	
Date of hire:	State of hire:	Wage rate: $

ACCIDENT INFORMATION

Type of accident: ☐ Injury ☐ Illness ☐ 3rd party ☐ Property damage

Date of injury:	Time employee began work:	AM / PM
Time of injury: AM / PM	Date notified:	Time notified: AM / PM

Who was notified:

Type of injury:
(e.g., reaction to foreign substance, puncture, laceration, contusion (bruise), fracture, amputation, strain/sprain, burn, etc.)

Part of body injured: ☐ Left ☐ Right ☐ N/A
(e.g., head, face, eye, ear, mouth, back, trunk, arm, wrist, hand, finger, knee, leg, ankle, etc.)

Safety equipment employee was using: ☐ Hard hat ☐ Safety glasses ☐ Back support ☐ Gloves
☐ Face shield ☐ Harness ☐ Other(s) (specify)

What activity was employee doing at the time of accident? making cuts with saw in brick wall

What happened to cause injury/illness?

Witness 1:	Phone:
Address:	
Witness 2:	Phone:
Address:	

MEDICAL TREATMENT INFORMATION (check all that apply)

☐ No medical treatment, for the file only	
☐ On site 1st aid only	Date of treatment:
☐ On site clinic	
☐ Off site clinic and clinic name:	Phone: ( )
☐ Hospital and hospital name:	Phone: ( )
☐ Post accident drug test	
☐ Treatment refused	
☐ Other (please explain)	

Work status: ☐ Full duty ☐ Modified duty ☐ Off work

DOCUMENTED BY:

Name:	Date: