

Accident Incident Report Checklist

Construction

DESCRIPTION OF WORKER INJURY

Was first aid provided?

☐ Yes☐ No☐ Na

Was medical aid provided?

☐ Yes☐ No☐ Na

Was there any time lost?

☐ Yes☐ No☐ Na

Any modified work

☐ Yes☐ No☐ Na

Was the injury fatal?

☐ Yes☐ No☐ Na

Name of worker

textarea

Age

textarea

Occupation

textarea

Nature of injury

textarea

DETAILS OF VEHICLE/PROPERTY DAMAGE

Add image

UPLOAD

Estimate cost/loss

textarea

Details of damage

textarea

GENERAL

Was there damage to the property?

Yes

No

Na

Date

DATE

2017-01-01

Type of accident

textarea

Person involved

textarea

Concerned department

textarea

Site supervisor on duty

textarea

Was there an injury?

Yes

No

Na

Was the injury severe?

Yes

No

Na

Was first aid provided?

Yes

No

Na

Did the damage have a major potential?

Yes

No

Na

Were there any spills?

Yes

No

Na

Any near miss reported?

Yes

No

Na

Was there a fire incident?

Yes

No

Na

Were any vehicles involved?

Yes

No

Na

Any other issue reported?

Yes

No

Na

Explain more

textarea

Add image

UPLOAD

Name of witness

textarea

SIGNATURES

Worker

SIGNATURE

Supervisor

SIGNATURE