


I'm not robot  reCAPTCHA

Open



+ Accident Record

Report Number (nonconsecutive)

Report Number (consecutive)

+ Accident Record

1. About the person who had the accident

Name _____
 Address _____
 City _____ State _____
 Zip _____

2. About you, the individual filling in this record

If you did not have the accident on the job, indicate your occupation:

Name _____
 Address _____
 City _____ State _____
 Zip _____

3. Details of the accident (Continue on the back of this form if you need to)

When it happened: Day _____ Month _____ Year _____
 Where it happened: State _____
 How did the accident happen?
 Give the details of the accident:
 If the person who had the accident suffered or may suffer grave injury:

4. Sign and date

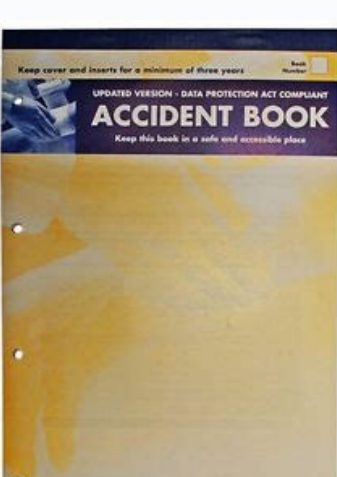
Person filing in the record:
 Print Name _____ Sign _____ Date _____
 Person who had the accident (as indicated) (Do not sign if the accident has been reported incorrectly):
 Print Name _____ Sign _____ Date _____

5. For the employer only

Complete this box if the accident is reportable under the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013 (RIDDOR).

How was it reported?
 Print Name _____ Sign _____ Date _____

ASSESSMENT PROFILE SHEET	
ASSESSMENT DATE: _____	Check One With "X"
OSHA: _____	<input type="checkbox"/> SELF PERFORM
OPER. CO.: _____	<input type="checkbox"/> CONSTRUCTION MGMT (CM)
CLIENT NAME: _____	
ASSESSOR(S)	LABOR POSTURE
Type Name/Location Here _____	<input type="checkbox"/> OPEN SHOP
Type Name/Location Here _____	<input type="checkbox"/> CONSTRUCTION
Type Name/Location Here _____	<input type="checkbox"/> MAINTENANCE
Type Name/Location Here _____	<input type="checkbox"/> UNION
	<input type="checkbox"/> OTHER
PROJECT INFORMATION	
PROJECT NAME: _____	
PROJECT NUMBER: _____	
PROJECT MANAGER: _____	
SITE MANAGER: _____	
SAFETY MGR/REP: _____	
PROJECT LOCATION	
CITY: _____	
STATE: _____	
COUNTRY: _____	
PROJECT REGION	
Check One With "X"	
<input type="checkbox"/> AMERICAS	<input type="checkbox"/> AFRICA
<input type="checkbox"/> ASIA PACIFIC	<input type="checkbox"/> EUROPE
<input type="checkbox"/> AUSTRALIA	<input type="checkbox"/> MID EAST
<input type="checkbox"/> EAST US	<input type="checkbox"/> WEST US
<input type="checkbox"/> CENTRAL US	<input type="checkbox"/> CENTRAL AMER.
<input type="checkbox"/> MEX	<input type="checkbox"/> S.A.
<input type="checkbox"/> CARIBBEAN	<input type="checkbox"/> OTHER
ASSESSMENT TYPE	
Check One With "X"	
<input type="checkbox"/> GENERAL	<input type="checkbox"/> REQUESTED BY PROJECT
<input type="checkbox"/> CONSULTATION	<input type="checkbox"/> POST ACCIDENT (Event Paid)
<input type="checkbox"/> POST FATALITY	<input type="checkbox"/> FOLLOW UP (Post Fatality)
<input type="checkbox"/> REQUESTED BY CLIENT	<input type="checkbox"/> OTHER
INJURY SUMMARY	
Total LWOC's - Project To Date: _____	Total Recordables - Project To Date: _____
Total LWOC's - Since Last Audit: _____	Total Recordables - Since Last Audit: _____



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