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| **Recordable Injury / Illness** | | | | | | | | | | | | | **First Aid** | | | | | | | | | | **Near Miss** | | | | | | | | | | | | | | | **Vehicle** | | | | | | | | | | | | | | **Spill Release** | | | | |
| **Security** | | | | | | | | | | | | | **Property Damage** | | | | | | | | | | **Process Interruption** | | | | | | | | | | | | | | | **Product Contamination**  **Agency Inspection** | | | | | | | | | | | | | | | | | | |
| Was this reportable to any governmental agency?  Yes  No | | | | | | | | | | | | | | | | | | | | | | | | | | | | | If Yes, list agency and person reported to: | | | | | | | | | | | | | | | | | |  | | | | | | | | | |
| 1. **GENERAL INFORMATION** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Contractor Company Name: | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Date of Report: | | | | | | | | | | | | | |  | | | | | | | | | | | Incident Date: | | | | | | | | | | |  | | | | Report Number: | | | | | | | | |  | | | | | | | |
| Event Time: | | | | | | | | | | | | | | am  pm | | | | | | | | | | | Time Zone: | | | | | | | | | | | Eastern  Central  Mountain  Pacific | | | | | | | | | | | | | | | | | | | | |
| Incident Description in Detail: | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| Incident Location: | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | Incident state or province: | | | | | | | | | | | | |  | | | | | | | | | | |
| Incident County or Parish: | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | Did Incident occur on TG property? | | | | | | | | | | | | | Yes  No | | | | | | | | | | |
| Is Incident location same as the work location? | | | | | | | | | | | | | | | | | | | | Yes  No | | | | | | | | | | | | |  | | | | | | | | | | | | |  | | | | | | | | | | |
| Enter specific details about the Incident location: | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| TG Project Manager: | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | TG EHS Representative: | | | | | | | | | | | | | |  | | | | | | | | | | | |
| 1. **EMPLOYEE INFORMATION:** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Name of employee: | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | Employee I.D. #: | | | | | | | | | | | |  | | | |
|  | | | | | | | | | | | | (First) (Middle) (Last) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | Date of Birth: | | | | | | | | | | | |  | | | |
| Employee’s home address: | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | Home Phone: | | | | | | | | | | | |  | | | |
|  | | | | | | | | | | | | | | (No. & Street) (City or Town) (State & Zip) | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | |
| 1. **WORK INFORMATION:** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Work shift: | | | | | | | call-out  overtime  regular | | | | | | | | | | | | | | | | | | | | | | | | | | | | Time shift began: | | | | | | am  pm | | | | | | | | | | | | | | | |
| Was work stopped? | | | | | | | Yes  No | | | | | | | | | | | | | | | | | | | | | | | | | | | | Date last worked: | | | | | |  | | | | | | | | | | | | | | | |
| Date began losing time: | | | | | | | | | | |  | | | | | | | | | | Date returned to work: | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | |
| Date employer notified: | | | | | | | | | | |  | | | | | | | | | | How many days/months/years has employee performed this job task? | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | |
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| 1. **MEDICAL TREATMENT INFORMATION:** (If applicable) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Was medical treatment provided? | | | | | | | | | | | | | | | | | Yes  No | | | | | | | | | Treatment in Emergency Room?  Yes  No | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Was party hospitalized overnight? | | | | | | | | | | | | | | | | | Yes  No | | | | | | | | | | Date of first medical care: | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | |
| Is this an OSHA recordable injury? | | | | | | | | | | | | | | | | | Yes  No | | | | | | | | | | Other: | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | |
| If yes, check below all that apply: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Chiropractic Treatment | | | | | | | | | Punctured Ear Drum | | | | | | | | | | | | | Loss of Consciousness | | | | | | | | | | | | | | | Received RX prescript. medication or equivalent | | | | | | | | | | | | | | Surgery | | | | | |
| Physical Therapy | | | | | | | | | Hearing STS | | | | | | | | | | | | | Fracture | | | | | | | | | | | | | | | Stitches | | | | | | | | | | | | | | Fatality | | | | | |
| Embedded object removed from eye | | | | | | | | | Light Duty or Restricted Work | | | | | | | | | | | | | Time away from work after the day of injury | | | | | | | | | | | | | | | Other, please explain: | | | | | | | | | | | | | | | | | | | |
| Physician’s name: | | | | |  | | | | | | | | | | | | | | | | | Treatment facility: | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | |
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| 1. **AGENCY INSPECTION:** (If applicable) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Announced  Unannounced | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Reason for Inspection: | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Agency Name: | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Federal  State  Local | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Inspector Name: | |  | | | | | | | | | | | | | | Inspector Contact Phone #: | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | |
| Description and Results of Inspection: | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| Citations Issued:  Yes  No | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 1. **INCIDENT DESCRIPTION:** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| What was the employee doing just before the incident occurred? | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| What object or substance directly harmed the employee? | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Nature of injury: | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | Body part injured: | | | | | | | | |  | | | | | | | |
| Fatality? | | | Yes  No | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | Fatality date: | | | | | | | | |  | | | | | | | |
| *If death occurred, give name, age, relationship and address of known dependent:* | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | Dependent’s age: | | | | | | | | |  | | | | | | | |
| Name of dependent: | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | Relationship: | | | | | | | | |  | | | | | | | |
|  | | | | | | | | | | (First) (Middle) (Last) | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | |
| Dependent home address: | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | Dependent phone #: | | | | | | | | |  | | | | | | | |
|  | | | | | | | | | | (No. & Street) (City or Town) (State & Zip) | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | |
| Name of witness: | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | Witness phone #: | | | | | | | | |  | | | | | | | |
|  | | | | | | | | | | (First) (Middle) (Last) | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | |
| 1. **CONTRACTOR – SUPERVISOR’S INVESTIGATION:** (Must be completed prior to submitting to TG Inspection) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| What were contributing causes of the accident? | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| What has been done to prevent recurrence? | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| When will the corrective action be completed? | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| **Name:** |  | | | | | | | | | | | | | | | | | | | | | | | | | | | **Title:** | | | | | |  | | | | | | | | | | | | | | | | **Date:** | | | |  | |
| (Supervisor or Foreman) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 1. **TG ONSITE PROJECT SAFETY, CRAFT INSPECTOR or PROJECT MANAGER REVIEW:** (Must be completed prior to submitting to TG Safety) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Do you agree with the results of this investigation? | | | | | | | | | | | | | | | | | | | | | | | | Yes | | | | | | | | No | | | | | | | | | | | | | | | | | | | | | | | |
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| If No, please explain: | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| What should be done to prevent recurrence? | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| What will you do to prevent recurrence? | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| When will corrective action be completed? | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| **Name:** |  | | | | | | | | | | | | | | | | | | | | | | | **Title:** | | | | | | | |  | | | | | | | | | | | | **Date Submitted:** | | | | | | | | | |  | |
|  | | | | (TG Onsite Representative) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |

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| **8. TG SAFETY REVIEW:** | | | | | | | |
| Do you agree with the results of this investigation?  Yes  No | | | | |  |  | | --- | --- | | If No, is a Root Cause Investigation required?  Yes  No | Yes  No | | | | |
| If not complete, date when investigation will be completed? | |  | | | | | |
|  | | | | | | | |
| **Investigation Facilitator:** |  | | **Title:** | |  | | |
| **Name:** |  | | **Title:** | |  | **Date:** |  |
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| 1. **Enablon: It is the TG EHS Field Safety Representative’s responsibility to ensure the incident is entered into Enablon.** | | | | | | | |

