|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| [ ]  **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: |  |
|       |
| 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: |  |
|       |
| 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? |       |
|  |
| 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: |       |
|   |
| 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: |  |
|  |
|  |
|  |
| 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?  |
|       |
|  |
| What has been done to prevent recurrence? |
|       |
|  |
| When will the corrective action be completed? |
|       |
| **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 |
|  |
| If No, please explain:  |       |
|  |
| What should be done to prevent recurrence?  |
|       |
|  |
| What will you do to prevent recurrence?  |
|       |
|  |
| When will corrective action be completed?  |       |
|  |
| **Name:** |       | **Title:** |       | **Date Submitted:** |       |
|  |  (TG Onsite Representative) |

|  |
| --- |
| **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:** |       |
|  |
| 1. **Enablon: It is the TG EHS Field Safety Representative’s responsibility to ensure the incident is entered into Enablon.**
 |

