

Incident Report - Full Investigation & Report Checklist

Incident Details

Date & Time of Incident:

Location of Incident:		
Incident Severity		
<input type="checkbox"/> Urgent	<input type="checkbox"/> High	<input type="checkbox"/> Medium <input type="checkbox"/> Low <input type="checkbox"/> Trivial
Site / Project Name: (enter text)		
Incident Type (select all that apply)		
<input type="checkbox"/> Hazard <input type="checkbox"/> Property Damage <input type="checkbox"/> Theft <input type="checkbox"/> Other	<input type="checkbox"/> Near-Miss <input type="checkbox"/> Fatality <input type="checkbox"/> Slip & Fall <input type="checkbox"/> Fire	<input type="checkbox"/> Accident <input type="checkbox"/> Reportable / Notifiable <input type="checkbox"/> Injury <input type="checkbox"/> Loss Time
Name of on-duty supervisor at time of incident (enter text)		
Was medical attention administered?	YES	NO

Incident Summary

Describe what happened. Please be detailed but state only facts. (enter text)		
Do you wish to include a timeline of events for this incident?	YES	NO
Build a timeline of key incident events below		
Event:		
Event Date / Time:		

Event Description: (enter text)	
What were the weather / environmental conditions at the time of the incident?	
<input type="checkbox"/> Clear	<input type="checkbox"/> Snow
<input type="checkbox"/> Cloudy	<input type="checkbox"/> Windy
<input type="checkbox"/> Rain	<input type="checkbox"/> Heatwave
	<input type="checkbox"/> Haze
	<input type="checkbox"/> Other

Evidence and Attachments:	
Which of the following do you need to attach to this report to accurately document this incident?	
<input type="checkbox"/> Evidence	<input type="checkbox"/> Equipment Details
<input type="checkbox"/> Vehicle Details	<input type="checkbox"/> Damages
	<input type="checkbox"/> Other Items
Please log all relevant evidence below	
Evidence	
Evidence Description (enter text)	
Evidence ID number (if applicable) (enter text)	
Type of evidence	
<input type="checkbox"/> Document	<input type="checkbox"/> Photos
	<input type="checkbox"/> Other
Photos of evidence (if applicable)	Attach photos
Please detail any further information regarding this evidence (if applicable) (enter text)	
Please log all relevant vehicle details below	
Vehicle	

Vehicle Make (enter text)	
Vehicle Model (enter text)	
Vehicle Registration (enter text)	
Driver (if applicable) (enter text)	
Photos of equipment (if applicable)	Attach Photos
Please detail any further information regarding this vehicle (if applicable) (enter text)	
Please log all relevant damage details below	
Damage	
Damage description (enter text)	
ID number (if applicable) (enter text)	
Photos of damage (if applicable)	Attach photos
Please detail any further information regarding this damage (if applicable) (enter text)	
Please log all relevant details of other items below	
Item	

Item description (enter text)	
ID number (if applicable) (enter text)	
Photos of item (if applicable)	Attach photo
Please detail any further information regarding this item (if applicable) (enter text)	
Please log all relevant equipment details below	
Equipment	
Equipment Make (enter text)	
Equipment Model (enter text)	
Equipment ID number (if applicable) (enter text)	
Photos of equipment (if applicable)	Attach photo
Please detail any further information regarding this equipment (if applicable) (enter text)	

People involved			
Please document all people involved in this incident			
Person			
Person			
Full Name (enter text)			
ID Number (enter text)			
Contact phone number (enter text)			
What is this person's relation to the incident? (select all that apply)			
<input type="checkbox"/> Reporter of incident <input type="checkbox"/> Injured person <input type="checkbox"/> Primary person involved <input type="checkbox"/> Secondary Involvement <input type="checkbox"/> On-duty supervisor <input type="checkbox"/> Investigator <input type="checkbox"/> Other <input type="checkbox"/> Witness <input type="checkbox"/> Suspect			
Please describe this person's involvement with the incident, including all relevant information (enter text)			
Attach any relevant photos regarding this person	Attach photo		
Do you want to log a statement for this person?	YES	NO	N/A

Has this person sustained an injury?		YES	NO
Type of injury or illness? (select all that apply)			
<input type="checkbox"/> Superficial	<input type="checkbox"/> Open Wound	<input type="checkbox"/> Fatality	
<input type="checkbox"/> Eye Injury	<input type="checkbox"/> Burns	<input type="checkbox"/> Electrocution	
<input type="checkbox"/> Dislocation	<input type="checkbox"/> Struck by object	<input type="checkbox"/> Entanglement	
<input type="checkbox"/> Nerve & Spinal Cord	<input type="checkbox"/> Amputation	<input type="checkbox"/> Intracranial	
<input type="checkbox"/> Fall	<input type="checkbox"/> Strain	<input type="checkbox"/> Sprain	
<input type="checkbox"/> Assault	<input type="checkbox"/> Muscle & Tendon	<input type="checkbox"/> Respiratory	
<input type="checkbox"/> Concussion	<input type="checkbox"/> Fracture	<input type="checkbox"/> Other	
Parts of body affected? (select all that apply)			
<input type="checkbox"/> General Ailment	<input type="checkbox"/> Back (Lower)	<input type="checkbox"/> Wrist (Right)	<input type="checkbox"/> Leg - Upper (Left)
<input type="checkbox"/> Head	<input type="checkbox"/> Arm - Upper (Right)	<input type="checkbox"/> Wrist (Left)	<input type="checkbox"/> Foot (Right)
<input type="checkbox"/> Eye (Right)	<input type="checkbox"/> Arm - Upper (Left)	<input type="checkbox"/> Hand (Right)	<input type="checkbox"/> Foot (Left)
<input type="checkbox"/> Eye (Left)	<input type="checkbox"/> Arm - Upper (Right)	<input type="checkbox"/> Hand (Left)	<input type="checkbox"/> Shoulder (Left)
<input type="checkbox"/> Ear Nose	<input type="checkbox"/> Arm - Elbow (Right)	<input type="checkbox"/> Chest	<input type="checkbox"/> Shoulder (Right)
<input type="checkbox"/> Throat	<input type="checkbox"/> Arm - Elbow (Left)	<input type="checkbox"/> Abdominal / Stomach	<input type="checkbox"/> Other
<input type="checkbox"/> Neck Back (Upper)	<input type="checkbox"/> Arm - Forearm (Right)	<input type="checkbox"/> Groin / Anus	
	<input type="checkbox"/> Arm - Forearm (Left)	<input type="checkbox"/> Leg - Upper (Right)	
		<input type="checkbox"/> Leg - Knee (Right)	
		<input type="checkbox"/> Leg - Knee (Left)	
		<input type="checkbox"/> Leg - Lower (Right)	
		<input type="checkbox"/> Leg - Lower (Left)	
		<input type="checkbox"/> Ankle (Right)	
		<input type="checkbox"/> Ankle (Left)	
Describe this injury or illness (enter text)			
What was the cause of this injury or illness? (Enter text)			
Corrective Actions			
Are corrective/further actions required with regard to this incident?		YES	NO
Root Cause Analysis / Contributing Factors			

What were the contributing factors to this incident occurring? (select all that apply)			
<input type="checkbox"/> Equipment Defects	<input type="checkbox"/> Employee operating at inappropriate speed		
<input type="checkbox"/> Lack of protective safety devices	<input type="checkbox"/> Lack of PPE		
<input type="checkbox"/> Equipment used outside rated capacity	<input type="checkbox"/> Safety procedures not followed		
<input type="checkbox"/> Untidy Conditions (Poor Housekeeping)	<input type="checkbox"/> Drugs or Alcohol		
<input type="checkbox"/> Inadequate ventilation	<input type="checkbox"/> Improper Equipment Use		
<input type="checkbox"/> Unauthorized Equipment Use	<input type="checkbox"/> Inappropriate PPE		
A Root Cause Analysis (RCA) is the process of determining the cause of an incident. It requires consideration of all the factors that may have contributed to this incident occurring and deeply understanding the underlying cause. One tactic to determine this is through asking "Why?" five times, to uncover the core of a problem.			
Has the root cause of this issue been able to be identified?	YES	NO	N/A
Sign Off			
Further action/follow-up/investigation required?	YES	NO	

Name & Signature of Investigator _____

Please note that this checklist is a hypothetical example and provides basic information only. It is not intended to take the place of, among other things, workplace, health and safety advice; medical advice, diagnosis, or treatment; or other applicable laws. You should also seek your own professional advice to determine if the use of such checklist is permissible in your workplace or jurisdiction.