



Incident Investigation Report

Instructions: Complete this form as soon as possible after an incident that results in any type of injury, illness, or near miss

Name of person involved _____ Male Female Other

Address _____

City _____ State _____ Zip _____

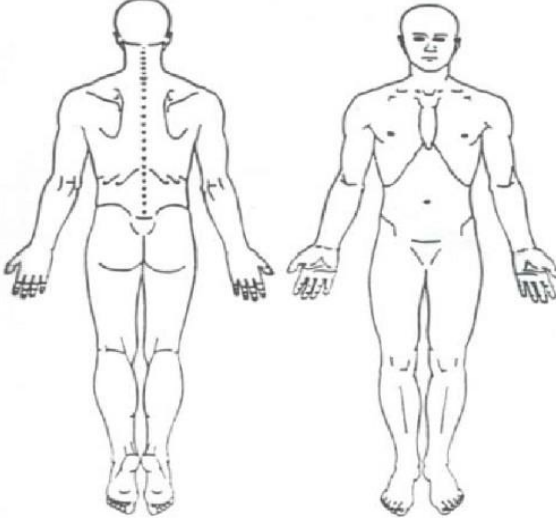
Phone Number _____ Home Cell Email Address _____ Marital Status Married Single

Job Title _____ Local Union _____ Contractor _____

This report is completed by Self Safety Supervisor Employee Client/Customer Contractor Sub-Contractor Other

Date of the Incident _____ This is a report of a Death Lost Time Hospital Visit First Aid Near Miss

Complete Only the Applicable Sections

Injured Employee <i>(skip this section if there were no injuries)</i>		
Part of the body affected <i>(shade all that apply)</i> 	Type of Injury <i>(Check the most Serious)</i> <input type="checkbox"/> Abrasion, Scrapes <input type="checkbox"/> Amputation <input type="checkbox"/> Broken Bone <input type="checkbox"/> Bruise <input type="checkbox"/> Burn (heat) <input type="checkbox"/> Burn (chemical) <input type="checkbox"/> Caught Between <input type="checkbox"/> Concussion <input type="checkbox"/> Crush Injury <input type="checkbox"/> Cut, Laceration, Puncture <input type="checkbox"/> Electrocution <input type="checkbox"/> Fall <input type="checkbox"/> Heat Related (stroke, exhaustion) <input type="checkbox"/> Hernia <input type="checkbox"/> Illness <input type="checkbox"/> Sprain, Strain <input type="checkbox"/> Struck by <input type="checkbox"/> Other _____	Type of Employee <input type="checkbox"/> Company Full Time <input type="checkbox"/> Company Part Time <input type="checkbox"/> Local Hall Full Time <input type="checkbox"/> Local Hall Part Time <input type="checkbox"/> Seasonal <input type="checkbox"/> Temporary
		Time with this employer
		Time on this job
		Job Duties with this employer

Describe the Location of the Injuries *(skip this section if there were no injuries)*

Was **WORKPARTNERS** Injury Hotline Called? Yes No If no, Why not? _____

Did the employee go to the hospital or need an ambulance? Yes No If yes, what hospital or clinic? _____

How could this have been prevented?

What was the **Exact Location** that this Injury occurred *(street address and site location, give details on whether it was inside/outside, new or old construction, etc.)*

What Part of the Employee's workday <input type="checkbox"/> Entering/Leaving work <input type="checkbox"/> Doing normal work activities <input type="checkbox"/> During Break/Lunch <input type="checkbox"/> Working Overtime	Time of Day <input type="checkbox"/> am <input type="checkbox"/> pm # of shifts: Working Shift 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/>
---	--

Describe in detail how the injuries occurred *(Give details about what work was being performed, any vehicles, equipment or tools (continue on the back if necessary))*

Were safety practices in place? *(If YES, what practice failed. If NO, why were practices not in place)*

Names of Witnesses *(each will be required to complete a witness statement)*

Accident or Property Damage *(skip this section if this incident did not involve an accident or property damage)*

What was the Exact Location of the Incident *(street address and location on site; give details on whether it was inside/outside, new/old construction, etc.)*

What Part of the Employee's workday <input type="checkbox"/> Entering/Leaving work <input type="checkbox"/> Doing normal work activities <input type="checkbox"/> During Break/Lunch <input type="checkbox"/> Working Overtime	Time of Day <input type="checkbox"/> am <input type="checkbox"/> pm # of shifts:
	Working Shift 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/>

Describe the incident in detail *(Give details about what work was being performed, any vehicles, equipment or tools continue on another sheet if necessary)*

Describe in detail how the incident could have been prevented *(Preventive measures, Safety gear or equipment, Inspections, More/Less personnel, etc.)*

Detail the damaged property *(provide area pictures and close up pictures of multiple angles of all property that was damaged. Alltech and Customer's property)*

Names of Witnesses *(each will be required to complete a witness statement)*

Why did the incident happen? *(If this was an injury or accident – Complete this section)*

Unsafe Workplace Conditions *(Check all that apply)*

- Inadequate guard
- Unguarded hazard
- Defective Safety Device, Tool, or Equipment
- Workstation layout is hazardous
- Unsafe lighting or Ventilation
- Lack of needed personal protective equipment (PPE)
- Lack of appropriate equipment / tools
- Unsafe clothing
- No training or insufficient training
- Other: _____

Unsafe Acts by People *(Check all that apply)*

- Operating without permission
- Operating at an unsafe speed
- Failing to Lock out/Tag out (LOTO) or bypassing a safety device
- Using defective or red tagged equipment
- Using equipment in an unapproved manner
- Body in a unsafe position/improper lifting *(ergonomics or lifting over 50lbs)*
- Distraction, teasing, horseplay
- Failing to wear PPE or wear the proper PPE
- Failure to use the appropriate tools or equipment
- Other: _____

Was this unsafe condition caused by Alltech Engineering or was it an existing condition? *(Please explain)*

Were the unsafe conditions known prior to work starting? Yes No *(if Yes, please explain)*

Have there been similar incidents prior to this one? Yes No *(if Yes, please explain)*

Could a stopgap been put in place to prevent this incident? Yes No *(if Yes or No, please explain)*

Is there a safety award system in place that promotes zero injuries? Yes No *(if Yes, please describe the system)*

How can future incidents be prevented? *(To be completed by Alltech Site Management)*

What are immediate actions that will prevent recurrence? *(check all that apply)*

- Stop the Activity Guard the Hazard Employee Training Supervisory Training Redesign Tasks Redesign Workplace Practices
- Institute New Policies/Procedures Enforce/Stress Current Policies Routine Inspections Improved/Better PPE Other

Number of Attachments	—————> Witness Statements	Photographs/Videos	Maps or Drawings
-----------------------	---------------------------	--------------------	------------------

What measures been instituted to prevent recurrence or future acts?

Review and Approval *(To be completed by Alltech Safety and Human Resources Manager)*

Reviewed by	Title
Signature	Date

Names of investigative team members

Approved by	Title
Signature	Date