DRI-CON INCIDENT/ACCIDENT REPORT FORM

INCIDENT/ACCIDENT REPORT

Please complete this form and return it to the office no longer than 24 hours after the incident
Actual Date of Incident: _____ Time: _____ am/pm
Employee Reported Incident To:_____ Date & Time Reported: _____

EMPLOYEE INFO.

Name (Last, First, M.I.)_____Sex:_____ D.O.B._____
Address_____City, State, Zip_____
Phone Number:_____ Does Employee Speak English?_____
Race (Optional)_____ Married:_____ No. Dep. Children_____
Employee Job Title:_____ Was employee doing their regular job?_____
If no, State Regular Job: _____ Project Name: _____ Job No._____

INJURY INFORMATION

Initial Medical Minor/Onsite Medical Clinic No Medical
1st Aid Administered by:_____ Taken by:_____ ER_____
Name of Clinic/Hospital: _____City,State:_____
If the employee chooses to waive his/her rights to medical treatment (explain why): _____
_____
Which part of the body was injured?_____
Nature of Incident: _____

INVESTIGATION

Where did the incident occur? _____
_____
How did the incident occur? (Describe in full detail)_____
_____
_____
Primary Cause: _____

CORRECTIVE ACTIONS

State those that have been take immediately as well as those to be taken: _____
_____
_____
Name of Witnesses (written statements):_____
Name of Translator (if necessary): _____
Name of Person Completed Form: _____ Signature: _____ Date:_____
Employee Signature: _____ Date: _____