TITAN
Risk Management, LLC

INCIDENT (ILLNESS / INJURY / DAMAGE) REPORT FORM

Location Code: ________

(1) Incident Date ________ (2) Day of week ☐ M ☐ T ☐ W ☐ T ☐ F ☐ S ☐ S (3) Time ________ ☐ AM ☐ PM

(4) Shift ☐ 1st ☐ 2nd ☐ 3rd (5) Job Name ______________________________

Specific Address or Location of Accident ______________________________

____

(6) On Employer's Premises? ☐ Yes ☐ No (7) Supervisor ______________________________

(8) Department (as applicable): ______________________________

(9) Injury or Illness?	☐ Yes	☐ No	If yes, complete below and Section I
(10) Vehicle damage involved?	☐ Yes	☐ No	If yes, complete below and Section II
(11) Property damaged?	☐ Yes	☐ No	If yes, complete below and Section III
(12) Property vandalized or stolen?	☐ Yes	☐ No	If yes, complete below and Section IV

Name of injured, ill or involved employee:

(13) First Name: ______________________________ Init: ____________ (14) Last Name: ______________________________

(15) SSN ______________________________ (16) Sex: ☐ M ☐ F (17) Age ________

(18) Employee No.: ________________ (19) Employee's Usual Occupation ______________________________

(20) Occupation at time of accident {If same as (19) above, leave blank} ______________________________

(21) Employment Category	(22) Length of Employment		(23) Time in Occupation	
☐ 1 Regular Full Time	☐ 1 In training	☐ 5 3-5 yrs	☐ 1 In training	☐ 5 3-5 yrs
☐ 2 Regular Part Time	☐ 2 < 6 months	☐ 6 5-10 yrs	☐ 2 < 6 months	☐ 6 5-10 yrs
☐ 3 Temporary	☐ 3 6 mos-1 yr	☐ 7 10-20 yrs	☐ 3 6 mos - 1 yr	☐ 7 10-20 yrs
☐ 4 Non-employee	☐ 4 1-3 yrs	☐ 8 20+ yrs	☐ 4 1-3 years	☐ 8 20+ yrs

(24) Witness(es): ______________________________ ______________________________

Address: ______________________________ ______________________________

Phone: ______________________________ ______________________________

(25) Description of Accident ______________________________

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Written: 02/16/11
Revised:
Reviewed:

SECTION I **For injury or illness Incident**

(26) Severity of Injury or Illness

- ☐ First Aid Only
- ☐ Medical Treatment
- ☐ Lost Workdays-restricted activity
  Number of Restricted Days________
- ☐ Lost Workdays-away from work
  Number of Lost Days_____________
- ☐ Fatality Date _______________

(27) OSHA illness code, if applicable

- ☐ Occupational Skin Disease or Disorders
- ☐ Dust diseases of the lung
- ☐ Respiratory Conditions due to Physical Agents
- ☐ Poisoning
- ☐ Disorders due to Physical Agents
- ☐ Disorders Associated with Repeated Trauma
- ☐ All other Occupational Illnesses

(28) Phase of employee's workday at time of accident

- ☐ 1 Performing work duties
- ☐ 2 During meal period
- ☐ 3 During rest period
- ☐ 4 Entering or leaving workplace
- ☐ 5 Chronic exposure
- ☐ 6 Other

(29) Describe the work employee was doing at time of accident:____

____

(30) Specific Activity____

(31) Employee was working ☐ 1 Alone ☐ 2 With a crew - Crew size _____ ☐ 3 Other

(32) Supervision at time of accident:

☐ 1 Directly supervised ☐ 2 Indirectly supervised ☐ 3 Not supervised ☐ 4 Supervision not feasible

(33) Name and Address of Physician ____

____

(34) Name and Address of Hospital / Clinic:____

____

Check the box(es) that apply in each category below:

(35) Body Part Affected

☐ Abdomen	☐ Ankle	☐ Arm	☐ Back	☐ Body (Gen'l)
☐ Brain	☐ Buttocks	☐ Cheek	☐ Chest	☐ Digestive, intestine
☐ Elbow	☐ Eye	☐ Face	☐ Finger	☐ Foot
☐ Forehead	☐ Genitals	☐ Groin	☐ Hand	☐ Head
☐ Heart	☐ Hips	☐ Kidney	☐ Knee	☐ Leg
☐ Lungs	☐ Mouth	☐ Multiple skeleton	☐ Misc.	☐ Neck
☐ Nervous System	☐ Nose	☐ Ribs	☐ Scalp	☐ Shin
☐ Shoulder	☐ Skull	☐ Spine	☐ Teeth	☐ Thigh
☐ Throat	☐ Thumb	☐ Toe	☐ Wrist	
			☐ Other	☐ Unknown

(36) Injury Type:

☐ Abrasion	☐ Amputation	☐ Arc Irritation	☐ Asphyxia	☐ Chemical burn
☐ Concussion	☐ Contusion	☐ Cut	☐ Dermatitis	☐ Dislocation
☐ Electrical Shock	☐ Foreign obj. (eye)	☐ Fracture	☐ Freezing	☐ Hearing Loss
☐ Heat burn	☐ Heat Stroke	☐ Hernia / Rupture	☐ Infect. disease	☐ Inflammation
☐ Irritation	☐ Laceration	☐ Multiple-Occ. disease	☐ Pneumoconiosis	☐ Poisoning
☐ Puncture	☐ Radiation	☐ Sprain, strain	☐ Other	☐ Unknown

SECTION I For injury or illness Incident - Continued

(37) Source of Injury:

☐ Air pressure	☐ Animal Products	☐ Animals	☐ Boxes / Containers	☐ Bodily Motion
☐ Boilers, valves	☐ Boxes/Containers	☐ Building structures	☐ Ceramics	☐ Chemicals
☐ Clothing	☐ Coal and petroleum	☐ Cold	☐ Conveyors	☐ Drugs & Medicines
☐ Electricity	☐ Excavations	☐ Fire, smoke	☐ Food products	☐ Furniture
☐ Glass	☐ Hand tools - non-powered	☐ Hand tools - powered	☐ Heat	☐ Hoists
☐ Infectious Agents	☐ Ladders	☐ Liquids	☐ Machines	☐ Metals, scrap
☐ Minerals, - metallic	☐ Minerals - nonmetallic	☐ Molten, metal	☐ Motion	☐ Noise
☐ None	☐ Other	☐ Paper	☐ Particles	☐ Plants
☐ Plastics	☐ Power Trans. Apparatus	☐ Pumps	☐ Power Trans. Apparatus	☐ Radiating subst.
☐ Scrap, debris	☐ Silica	☐ Soaps, detergents	☐ Steam	☐ Textiles
☐ Unknown	☐ Vehicles, forklifts	☐ Wood	☐ Work Area	☐ Working surfaces

(38) Type of Accident:

☐ Absorption	☐ Arc-Ray Exposure	☐ Bodily reaction	☐ Caught in or between	☐ Electric current
☐ Electrocution	☐ Fall from different level	☐ Fall on same level	☐ Ingestion	☐ Inhalation
☐ Irritation	☐ Motor vehicle	☐ Other	☐ Overexertion	☐ Traffic
☐ Radiations, caustics	☐ Rub, abraded	☐ Slip, not fall	☐ Sprain	☐ Strain
☐ Struck against	☐ Struck by	☐ Temp. extremes	☐ Unknown	☐ Vehicle
☐ Wind blown obj.				

(39) Hazardous Conditions:

☐ Defects of agencies	☐ Dress/Apparel	☐ Employees' Unsafe Act	☐ Environmental hazards	☐ Hazardous procedures
☐ Inadequately guarded	☐ None	☐ Other	☐ Placement hazard	☐ Public hazards
☐ Unknown	☐ Work environments			

SECTION II For Vehicle Incident

GENERAL INFORMATION

(40) Drivers' License No.:________________ **(41)** State:______________

(42) Drivers' Vehicle: _______________ **(43)** Yr.:________ **(44)** Make:______________ **(45)** Unit No.: ________

(46) Vehicle License No.: ______________________ **(47)** State if other than NC: ________

(48) Vehicle company owned: Yes ☐ No ☐

(49) Direction of vehicles:
Yours ☐ North ☐ South ☐ East ☐ West
Other ☐ North ☐ South ☐ East ☐ West

(50) Speed:
Yours ________ Posted Limit ________
Other ________ Posted Limit ________

TRAFFIC CONTROL:

(51): ☐ one-way ☐ two-way ☐ three way ☐ four way ☐ stop sign
☐ yield ☐ police/flag person ☐ railroad crossing ☐ uncontrolled intersection
☐ not an intersection

(52) Seat Belt: ☐ used ☐ not used **(53)** Air Bag Inflated? ☐ Yes ☐ No

ACCIDENT SKETCH

(54) Provide sketch and send to Safety Department immediately. Show each vehicle position, any pedestrians, and stop signs, yield signs, etc. Also, include point of impact, label street names and show which way is north.

SECTION II For Vehicle Incident - Continued

INJURIES

If any Injuries, list employee first and others after.

(55) Injured name________________________ Address______________________________

Phone number ________________________

(56) Other injured________________________ Address______________________________

Phone number ________________________

(57) Other injured________________________ Address______________________________

Phone number ________________________

POLICE OFFICER ASSISTING:

(58) Police Report Made? ☐ Yes ☐ No (59) Police Incident No. ____________

(60) Name ____________________________________(61) Badge No. ____________

PROPERTY DAMAGE

(62) Describe damage to your vehicle: ____

(63) Other Vehicle(s) damage: ____

____

(64) Driver of other vehicle:________________________ License No.____________ State____________

Phone No.________________________ Address: ______________________________________

(65) Vehicle Make/Yr.______________________(66) License No. ____________

(67) Insurance co.________________________(68) Phone No. ____________(69) Policy No.________

(70) Property damage other than Vehicle(s)____

(71) Owner of property if different than above__________________ (72) Phone No. ____________

Address:______________________________

(73) Witness(es): ______________________________ ______________________________

Address:______________________________ ______________________________

Phone: ______________________________ ______________________________

SECTION III For Damaged Property

PROPERTY DAMAGE

(74) Describe insured property damages: ____

____

(75) List other property damage: ____

(76) Owner of property:____________________ (77) Address: ______________________________

(78) Phone no. ________________________

(79) Property Make/Yr.____________________ (80) Model no. ____________

(81) Insurance co.________________________ (82) Phone no. ____________ (83) Policy No.________

Written: 02/16/11
Revised:
Reviewed:

SECTION III For Damaged Property

WITNESSES:

(84) Witness(es): ______________________ ______________________

Address: ______________________ ______________________

Phone: ______________________ ______________________

POLICE OFFICER ASSISTING:

(85) Police Report Made? ☐ Yes ☐ No **(86)** Police Incident No. __________

(87) Name ______________________ **(88)** Badge No. __________

(89) Describe how incident occurred: ______________________

____

____

____

(90) Other details not listed above: ______________________

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____

SECTION IV For Property Stolen or Vandalized

☐ **STOLEN** ☐ **VANDALIZED PROPERTY LIST:**

(91) List Item: ______________ Serial No.: __________ Model No.: __________

Company unit no.: ______________ Estimated Value: __________

(92) List Item: ______________ Serial No.: __________ Model No.: __________

Company unit no.: ______________ Estimated Value: __________

(93) List Item: ______________ Serial No.: __________ Model No.: __________

Company unit no.: ______________ Estimated Value: __________

Note: If more than three (3) items taken or damaged, list on separate page.

POLICE OFFICER ASSISTING:

(94) Police Report Made? ☐ Yes ☐ No **(95)** Police Incident No. __________

(96) Officer's Name: ______________________ **(97)** Badge No. __________

(98) Describe what is known or what occurred: ______________________

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SECTION IV **For Property Stolen or Vandalized -Continued**

SECURITY:

(99) Was property secured: ☐ Yes ☐ No

(100) Was property owned by company: ☐ Yes ☐ No

by you? ☐ Yes ☐ No

by others ☐ Yes ☐ No

(101) If secured, was property in: ☐ Tool Shed/Container Box ☐ Office Trailer ☐ Fenced in area

☐ Other (describe) ______________________________

WITNESSES:

(102) Witness(es): ______________________________ ______________________________

Address: ______________________________ ______________________________

Phone: ______________________________ ______________________________

(103) Other details not listed above:______________________________

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