INSTRUCTIONS FOR CONTRACTOR ACCIDENT/INCIDENT FORMS

1. All forms must be completed in detail, and in legible handwriting or typed. If handwritten, please print in legible handwriting.

2. Complete forms must be submitted to the University within 24 hours of the accident/incident. If the form cannot be completed in that time frame (due to extent of injuries or availability of the injured party), please contact the University with preliminary information. Incomplete forms may be submitted as part of the preliminary information. However, completed versions must be submitted as soon as possible.

3. Incomplete forms or outdated forms will be sent back to the individual for revisions.

4. Please review the forms in detail. Make sure that everything is complete.

5. If a subcontractor is involved, please follow up with them to determine the extent of injuries. We are tracking their incidents/accidents as well.

6. The only information needed on page 3 (Medical Release) is the name of the individual, his or her social security number, the date and a signature. The rest of the form will be completed during the follow-up process. Please ask the employee to sign this form regardless of the severity of the injury.

7. If the incident involves a fatality or the hospitalization of one or more individuals, please contact the University immediately.

REMINDERS:

1. Are the forms thoroughly completed with the necessary details?

2. Do you have the necessary signatures?

3. Is the information, including names, legible?

4. If a Contractor employee was injured:
   a. Did he or she complete the appropriate sections on the forms in his or her own handwriting?
   b. Did you get a signature on the medical release form?

5. Did you fax the completed forms to the University within 24 hours of the incident?

6. If the forms could not be faxed or emailed within 24 hours, did you contact the University with preliminary information?

7. Did you ensure that the injured party is stabilized and/or receiving appropriate treatment?

8. How are the rest of the employees handling the incident/accident?

9. Did you follow up with the subcontractor(s) in terms of extent of injuries and/or resulting medical treatment?

10. If the accident involved blood or other potentially infectious material, did you contain the material and dispose of it properly?

11. Did you contact the designated client representative (if applicable)?

12. Did you use additional pages if necessary to describe the accident/incident?

13. Was a drug and alcohol test performed (if applicable) and results submitted to the COATS database administrator?
CONTRACTOR ACCIDENT / INCIDENT REPORT

Please Select Type:

☐ Employee Injury  ☐ Accident  ☐ Property Damage/Stolen Property
☐ Subcontractor Injury  ☐ Incident

INJURED PARTY/CLAIMANT:

Name: ___________________________________________  SS#: _______________________
Address: ___________________________________________  Home Phone #: __________________

City, State, Zip: _________________________  Date of Birth: _________________________
 Employer: ________________________________________________
Occupation When Injured: ________________________________________________

TIME AND PLACE OF ACCIDENT / INCIDENT

Did Accident Occur on University Premises?  ☐ Yes  ☐ No
 Accident Location (Job Name): ______________________________  Job No.: ______________________________
Address: ___________________________________________  State/Zip: _________________________
Date: __________  Time: __________  Lost Time:  ☐ Yes  ☐ No

Name of Foreman/Supervisor: ________________________________________________

Last Day Worked: _________________________  Return to Work: _________________________
Reported to Employer: ________________________________________________
To Whom was Accident Reported: ________________________________________________

Were University Personnel On Site When the Accident/Incident Occurred?  ☐ Yes  ☐ No

DESCRIPTION OF ACCIDENT / INCIDENT (completed by employee)

See Attached Employee Description

WITNESS CONTACT INFORMATION

See Attached Witness Contact Info

MEDICAL ATTENTION:

Was Medical Attention Provided:  ☐ Yes  ☐ No  When: _________________________
 Name of Doctor/Hospital: ______________________________  Phone No.: _________________________
Address of Doctor/Hospital: ______________________________

Did this accident/incident meet the criteria for a post-accident/incident drug and alcohol test as defined by the
COATS Substance Abuse Program?  ☐ Yes  ☐ No

If yes, were applicable drug and alcohol tests performed and submitted to the COATS database administrator?  ☐ Yes  ☐ No
If no, explain why: ________________________________________________

SIGNING THIS REPORT DOES NOT CONSTITUTE CERTIFICATION OF AN INDUSTRIAL CLAIM (signatures)

Employee Signature  Date  University Project Administrator Signature  Date

Employee (typed or printed)  University Project Administrator (typed or printed)  Phone

NOTE: THIS REPORT MUST BE TRANSMITTED TO THE UNIVERSITY WITHIN 24 HOURS OF THE ACCIDENT/INCIDENT

cc: University Environmental Health & Safety
File 0031A
ACCIDENT / INCIDENT IN QUESTION:

Is the Injured Party a Contractor’s Employee? ☐ Yes ☐ No  Subcontractor? ☐ Yes ☐ No

Please Provide a Description (In Detail) of Occurrence:

Did Anything Contribute to the Accident / Incident? (i.e., Environmental or external factors, another contractor, carelessness, lack of sleep, etc.)

Had this Contributing Factor Been Discussed in Pre-Construction or Gang Box Meetings: ☐ Yes ☐ No

CORRECTIVE ACTION INVOLVED:

Initial Response/Action to Incident (Please Describe):

Long Term Corrective Measures (Please Describe):

How was Corrective Actions Communicated to the Workers?

PERSONAL PROTECTION EQUIPMENT USED AT TIME OF INCIDENT (BY INJURED PARTY) – PLEASE CHECK ALL THAT APPLY.

☐ Hard Hat ☐ Full Body Harness and Lanyard
☐ Safety Glasses / Goggles ☐ Hearing Protection
☐ Face Shield ☐ Respiratory Protection
☐ Work Boots ☐ Other: ________________________________
☐ Gloves

SAFETY DEPARTMENT COMMENTS / FOLLOW UP:

NOTE: THIS REPORT MUST BE SUBMITTED TO THE UNIVERSITY WITHIN 24 HOURS OF THE ACCIDENT/INCIDENT

CC: UC Environmental Health & Safety, File 0031A
Date

Accident Location (Job Name): 0 Job No.: 0

Describe in Detail what Occurred:

Exact Nature and Part of Body Affected (e.g., fracture of right hand, cut finger, etc.) (If applicable):

Property Damage (if applicable):

Have you ever had any Other Medical Treatment or Injury to Part(s) of Body Listed Above, Either Before or After this Injury? If so, Explain in Detail and Give the Name of Treating physician.

Are you Reporting this Accident as an Industrial (work related) Injury?  Yes  No
CONTRACTOR ACCIDENT / INCIDENT REPORT
WITNESS CONTACT INFORMATION

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Contractor Accident / Incident Report
Rev 8/1/2005
Name: ___________________________  Title: ___________________________

Social Security Number: ____________  Date: ____________  Time: ____________

Employer: _____________________________________________________________

Address: _____________________________________________________________  Phone No.: ______________________

Location at Time of Accident / Incident:

Describe to the best of your knowledge what happened before, during, and after the accident:

____________________________________________________________

Signature

Attach to Accident / Incident Report

cc:  UC Environmental Health & Safety
     File 0031A

Witness Statement  Rev 8/1/2005