



COMPANY HEALTH AND SAFETY PROGRAM

Document No. 3.1.1

Date: August 4, 2006

Incident Report Form

Revision: 0

Type of Incident

Injury/exposure only Property loss only Injury and property loss Reportable incident without injury or property loss

Project Number: _____ Project Name: _____ Date of Incident: _____ Time: _____ AM PM

Incident Location: _____ Conditions: _____

Name(s) of witnesses, if any: _____

Employer: _____ Employer Contact: _____

*If incident caused death or serious injury, this information must be called in to the Health & Safety Manager or Company President **immediately!***

Injury/Exposure

Injured employee's name: _____ Body part injured/affected: _____ Degree of damage/symptoms: _____

Date of Birth: _____ Date of Hire: _____ SSN: _____ Wage Rate: _____

Did injured see a physician? Yes No Name and address of treating physician (and/or hospital): _____ Date of visit: _____

Care/treatment provided: _____

Employee activity/task involved: _____ Object/equipment involved: _____

Detailed description of incident: _____ PPE used: _____

Injury classification: Struck By Contacted By Struck Against Contact with Caught in
 Caught Between Fall to Below Fall to Level Exposure Over Exertion

Property Damage/Loss/Theft

What was damaged, lost, or stolen? _____ Amount of damage/lost/theft: _____

Was this reported to police? Yes No If yes, list department(s) involved: _____

Corrective Action


Identify actions taken to prevent or minimize occurrence of any future incidents: _____ Was work stopped until corrected? How? _____

Signature

Name of person completing form:(Print) _____ Signature: _____ Date: _____

Employee Signature: _____ Date: _____

Return this report to the Safety Department or Office Manager as soon as possible.

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- 1) **STOP** - Failure to stop is a violation. Do not move the vehicle or equipment from the scene until emergency personnel, project supervisor, and/or police arrive, unless otherwise required by law or to save a life.
- 2) **PROTECT THE SCENE** - Turn on hazard flashers, set out warning devices, and/or barrier off the scene.
- 3) **NOTIFY** - Call the appropriate emergency numbers (e.g., Police, fire, ambulance, 911, etc.).
- 4) **NOTIFY** - Call project points-of-contact (e.g. project supervisor, health and safety manager, contractor/consultant). Give information in format outlined below.
- 5) Complete all applicable sections of the Incident Report and distribute accordingly.

The report is required to be completed if an incident involves the following:

- A work-related injury, illness, or exposure affecting a Hallen Environmental Services employee or other personnel working or visiting the location.
- Property theft, loss, or damage through an accident, mechanical failure, weather conditions, etc.
- List any witnesses and their company affiliation, if known. If there is a death or serious injury, the Health and Safety Manager and Director of Environmental Services must be notified **immediately**.

A Report of Injury form for New York worker's compensation must also be completed for any Hallen employee injury. The Safety department will have the form available for the supervisor or manager to complete.

Examples: Job factors may include long work hours, improper equipment, and failure of safety devices, etc.

- Unsafe conditions may include weather, poor ventilation or lighting, traffic, slippery ground, etc.
- Unsafe practices may include failure to use safety devices, failure to follow company programs, policies, or procedures, etc.
- Personal factors may include lack of sleep, prior illness, improper training, etc.



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FORM FOR REPORTING PROPERTY DAMAGE

A. NAME & ADDRESS OF OWNER:

**B. KIND OF PROPERTY -
DAMAGE & EXTENT:**

C. DATE & TIME OF ACCIDENT:

_____ AM _____ PM

D. JOB LOCATION:

E. NAME OF FOREMAN: (w/ employee #)

_____ **JOB #** _____

F. FULL DESCRIPTION & CAUSE:

G. NOTES:

H. PREVENTABLE:


I. SUPER:

PREPARED BY: _____

DATE: _____

PLEASE SEND COMPLETED FORM TO STU BUHRENDORF

**REPORT SERIOUS ACCIDENTS BY TELEPHONE TO DISPATCHER –
1-718-533-9400**

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FORM FOR REPORTING WORKER'S COMPENSATION CASES

1. NAME & ADDRESS OF INJURED PERSON: _____

2. DATE OF BRITH: _____

3. SOCIAL SECURITY #: _____

4. MARRIED: YES _____ NO _____

5. OCCUPATION (TITLE): _____
 HOURLY RATE: _____ HOW LONG: _____

6. DATE INJURED: _____ TIME: _____

7. FOREMAN: _____ SUPER: _____ JOB # _____
 (please list employee #)

8. LOCATION OF ACCIDENT: _____

9. NATURE OF INJURY: _____

10. NAME & ADDRESS OF HOSPITAL: _____

DOCTOR: _____
 DATE OF FIRST VISIT: _____

11. HOW DID ACCIDENT HAPPEN – EXPLAIN BRIEFLY:


12. WHAT COULD YOU HAVE DONE DIFFERENTLY TO AVOID THIS INJURY:

13. LOST TIME? YES _____ NO _____
 PREPARED BY: _____ DATE: _____

14. LAST INJURY, DATE & NATURE: _____

COMMENTS BY SAFETY MGR: _____

PLEASE SEND COMPLETED FORM TO STU BUHRENDORF
REPORT SERIOUS ACCIDENTS BY TELEPHONE TO DISPATCHER –
1-718-533-9400

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Procedure to Reopen Workers' Compensation Claim

If injured employee wishes to reopen a claim that has been closed, his doctor should file a C-27 with the Workers' Compensation Board, preferably the same one that handled the original claim.

In the case of any claim covered by Reliance (now in liquidation) the board will notify the liquidator and they will appear.

If an employee wishes to contact the liquidation bureau the address is:
State of New York, Insurance Department, Liquidation Bureau, 123 William Street, New York, NY 10038

NOTE: Any claim settled under Section 32 Settlement CAN NEVER BE REOPENED.

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FORM FOR REPORTING BODILY INJURY CLAIMS

(ONLY INJURIES TO MEMBERS OF THE PUBLIC)

A. NAME OF INJURED: _____

ADDRESS OF INJURED: _____

AGE OF INJURED: _____

B. NATURE OF INJURIES: _____

C. DATE & TIME OF ACCIDENT: _____

D. LOCATION: _____

E. NAME OF FOREMAN: _____ JOB #: _____

F. FULL DESCRIPTION & CAUSE: _____

G. NAME OF DOCTOR AND/OR HOSPITAL: _____

H. POLICE REPORT: _____

PREPARED BY: _____ DATE: _____

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THEFT REPORT

NAME OF PROPERTY OWNER: _____

STREET ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

TELEPHONE #: _____

DATE OF THEFT: _____ TIME: _____ AM _____ PM _____

LOCATION: _____

CONTRACT #: _____

DESCRIPTION OF PROPERTY/SERIAL #: _____

DESCRIPTION OF THEFT & CAUSE: _____

WITNESS: _____


ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

TELEPHONE #: _____

Policy report: YES _____ NO _____ IF YES, PCT./CASE #: _____

PREPARED BY: _____ DATE: _____

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VEHICLE ACCIDENT REPORT

DATE OF ACCIDENT _____ TIME _____ LOCATION _____

WEATHER CONDITIONS _____ TRAFFIC CONDITIONS _____

POLICE PRECINCT NAME & NO. _____ CASE # _____

INJURIES? YES _____ NO _____

NAMES & ADDRESSES OF INJURED _____

WITNESSES? YES _____ NO _____

NAMES & ADDRESSES OF WITNESSES _____

HALLEN VEHICLE # _____ MAKE _____ MODEL _____ YEAR _____

V.I.N. _____ PLATE # _____

DIRECTION OF TRAFFIC (CHECK ONE) N _____ S _____ E _____ W _____

DRIVER'S NAME & EMP. # _____ LICENSE # _____

DATE OF BIRTH _____ CONTRACT # & SUPER _____

HOME ADDRESS _____

OCCUPANTS IN HALLEN VEHICLE _____

DAMAGE TO VEHICLE _____

OTHER VEHICLE: MAKE _____ MODEL _____ YEAR _____ PLATE _____ STATE _____

DRIVER'S NAME _____ LICENSE # _____

DATE OF BIRTH _____

OWNER OF ABOVE VEHICLE _____

ADDRESS OF OWNER _____

OCCUPANTS IN OTHER VEHICLE _____

INSURANCE INFO: _____

DAMAGE TO VEHICLE _____

ACCIDENT DESCRIPTION:

DRAW A SKETCH ON BACK OF REPORT

REVIEW COMMITTEE ANALYSIS:

REVIEW CHAIRMAN: _____ DATE: _____

PLEASE FILL IN ALL ITEMS & SEND COMPLETED FORM TO STU BUHRENDORF