CROSS COUNTRY
INFRASTRUCTURE SERVICES INC.

Incident Investigation Report

Investigator: _____ Report Date: _____ / _____ / _____

Incident Resulted In: ☐ Near Miss ☐ Equipment Damage ☐ Property Damage ☐ Injury ☐ Fatality

When did the incident occur? Date: _____ / _____ / _____ Time: ____ : ____a.m./p.m.

Is the incident/injury reportable to OSHA? ☐ No ☐ Yes – Date reported to OSHA: _____ / _____ / _____

Involved Employee Information:

Name: _____ _____ _____
LAST FIRST MI

Address: _____ _____ _____ _____
STREET CITY STATE ZIP

Home Phone: _____ Mobile Phone: _____

D.O.B.: _____ Gender: _____

Occupation: _____

Was the employee Drug Tested? ☐ No ☐ Yes – Results: _____

Was the employee Alcohol Tested? ☐ No ☐ Yes – Results: _____

Employer Information:

Company Name: _____

Supervisor's Name: _____ _____ _____
LAST FIRST MI

Telephone: _____ Fax Number: _____

Company Address: _____ _____ _____ _____
STREET CITY STATE ZIP

Witness Information: ☐ No Witnesses

Name: _____ _____ _____
LAST FIRST MI

Statement Attached? ☐ Yes ☐ No (If no, explain) _____

Name: _____ _____ _____
LAST FIRST MI

Statement Attached? ☐ Yes ☐ No (If no, explain) _____

Name: _____ _____ _____
LAST FIRST MI

Statement Attached? ☐ Yes ☐ No (If no, explain) _____

Incident Investigation Report (cont'd)

Incident Information:

When was the incident reported to supervisor? Date: ____ / ____ / ____ Time: ___ : ___a.m./p.m.

Job Site Address: _____ _____ _____ _____
STREET CITY STATE ZIP

Specific Location Where Incident Occurred: _____

The incident occurred while working: ☐ Inside ☐ Outside

Conditions (*if outside*): ☐ Sunny ☐ Excessive Heat ☐ Dry ☐ Rainy ☐ Snowy ☐ Excessive Cold

What was the involved employee doing at the time of the incident?

Describe how did the incident occurred:

Describe any Property damage:

Describe any Equipment damage:

What environmental factors (unsafe conditions) contributed to the incident? *(see supplemental information)*

What behavioral factors (unsafe acts) contributed to the incident? *(see supplemental information)*

What corrective actions have been taken to prevent incident recurrence?

Incident Investigation Report (cont'd)

Injury Information:

When was the injury reported to supervisor? Date: _____ / _____ / _____ Time: ____ : ____a.m./p.m.

Type of Medical Treatment administered: (check all applicable)

- ☐ None
- ☐ On-Site first aid
- ☐ Doctor/Clinic visit
- ☐ EMT/Paramedic
- ☐ Emergency Room
- ☐ Hospital Stay

Type of Injury/Illness that was incurred: (check all applicable)

- ☐ Abrasion
- ☐ Allergic Reaction
- ☐ Animal Bite
- ☐ Asphyxiation
- ☐ Blister
- ☐ Burns
- ☐ Cardiovascular
- ☐ Concussion
- ☐ Contusion (bruise)
- ☐ Crushing Injury
- ☐ Dermatitis
- ☐ Dislocation
- ☐ Electrocution
- ☐ Exposure-Chemical
- ☐ Exposure-Radiation
- ☐ Eye Cases
- ☐ Fracture
- ☐ Hearing Loss-Temp.
- ☐ Hernia
- ☐ Laceration
- ☐ Poisoning
- ☐ Puncture
- ☐ Repetitive Motion
- ☐ Splinter
- ☐ Sprain (joint)
- ☐ Sting-Insect Bite
- ☐ Strain (muscle)
- ☐ Temperature-Extreme Hot or Cold
- ☐ Unclassified

Injury Caused by: (check all applicable)

- ☐ Burns
- ☐ Caught in/between
- ☐ Climbing
- ☐ Cut/Puncture
- ☐ Electrical Shock
- ☐ Explosion
- ☐ Fall - Elevation
- ☐ Fall - Same Level
- ☐ Fall – Climbing
- ☐ Falling Object
- ☐ Irritation
- ☐ Lifting./Handling
- ☐ Motor Vehicle
- ☐ Natural Disaster
- ☐ Reaching for…
- ☐ Struck against…
- ☐ Struck by…
- ☐ Violence

Body Part that was injured: (check all applicable)

- ☐ Head
- ☐ Face
- ☐ Ear ☐ R ☐ L
- ☐ Eye ☐ R ☐ L
- ☐ Nose
- ☐ Mouth
- ☐ Throat
- ☐ Neck
- ☐ Back
- ☐ Chest
- ☐ Stomach
- ☐ Kidney ☐ R ☐ L
- ☐ Buttock ☐ R ☐ L
- ☐ Groin ☐ R ☐ L
- ☐ Hip ☐ R ☐ L
- ☐ Leg ☐ R ☐ L
- ☐ Knee ☐ R ☐ L
- ☐ Ankle ☐ R ☐ L
- ☐ Foot ☐ R ☐ L
- ☐ Toes ☐ R ☐ L

(circle)

- ☐ Shoulder ☐ R ☐ L
- ☐ Arm ☐ R ☐ L
- ☐ Elbow ☐ R ☐ L
- ☐ Wrist ☐ R ☐ L
- ☐ Hand ☐ R ☐ L
- ☐ Fingers ☐ R ☐ L

(circle)

Medical Treatment Information:

Hospital/Clinic Name: _____ Telephone: _____

Address: _____ _____ _____ _____
STREET CITY STATE ZIP

Attending Physician: _____ Telephone: _____

Address: _____ _____ _____ _____
STREET CITY STATE ZIP

Recommendation of the doctor: ☐ Return to Regular Work ☐ Restricted Work ☐ Days off Work

Number of Days to be off Work: _____ Date to Return to Restricted Work: _____ / _____ / _____

Number of Restricted Work: _____ Date to Return to Regular Work: _____ / _____ / _____

Incident Investigation Report (cont'd)

Supervisor Information:

I certify that I have reviewed all information contained on this Incident/Near Miss Report and am taking the appropriate actions to completely investigate the incident, as well as to report any required findings.

Reported to Costello Safety Consulting: Date: _____ / _____ / _____ Time: ____ : ____a.m./p.m.

Name of person to whom it was reported: _____

Reported to OSHA (if applicable): Date: _____ / _____ / _____ Time: ____ : ____a.m./p.m.

Signature:

_____ _____ _____ / _____ / _____
PRINT SIGNED DATE

Costello Safety Consulting Information:

Safety Representative Completing Investigation:

_____ ☐ Photos Attached to Report

Incident Notes:

Recommended Remediation:

Costello Safety Consultant Signature:

_____ _____ _____ / _____ / _____
PRINT SIGNED DATE