Division of Administration and Finance
Planning + Design + Construction
PO Box 210186
Cincinnati, Ohio 45221-0186

INSTRUCTIONS FOR CONTRACTOR ACCIDENT/INCIDENT FORMS

1. All forms must be completed in detail, and in legible handwriting or typed. If handwritten, please print
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 Incomplete forms or outdated forms will be sent back to the individual for revisions.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?

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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

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CONTRACTOR
ACCIDENT / INCIDENT REPORT

ACCIDENT / INCIDENT IN QUESTION:

University Project Administrator (typed or printed) _____ Date _____

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

SAFETY DEPARTMENT COMMENTS / FOLLOW UP:

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DESCRIPTION OF ACCIDENT / INCIDENT (completed by employee)

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

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CONTRACTOR ACCIDENT / INCIDENT REPORT
WITNESS CONTACT INFORMATION

Date

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

Name:

Address:

City, Zip:

Phone #:

Name:

Address:

City, Zip:

Phone #:

Name:

Address:

City, Zip:

Phone #:

Name:

Address:

City, Zip:

Phone #:

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WITNESS STATEMENT

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