SAWs Initial Accident/Injury Report

Please Note: This form must be completed by the Project Manager for all injuries regardless of the nature or severity. Use this form to report accidents, injuries, or medical situations. The report should be completed within 24 hours of the event. Submit completed form and Accident Investigation Form to the Operations Manager.

INFORMATION ABOUT THE PERSON INVOLVED IN THE ACCIDENT:

Full Name ____ Male _____Female_____

Address____Date of Birth ______________

City_________________ County ______________State & Zip ______________Phone________________

Unmarried____ Married____ Spouse Name ____

INFORMATION ABOUT THE ACCIDENT:

Date of Incident ____________________ **Time** ________________

Location of Incident ____

Specific Activity and Work Process Individual was engaged in when accident occurred. Be as specific as possible. ____

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Was the individual injured? If so, describe the injury (laceration, sprain, etc., the part of the body injured, and any other information known about the resulting injury(s).

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Was medical treatment provided? ____No ____ Yes ____ Refused If yes, where was treatment provided? -

On Site_____ Urgent Care _____ Emergency Room _____ Other: Provider: _________________________

If no or refused, Individual must sign here ____

Investigator Signature: ____ Date: ___________

Investigator's Name (print): ____

Witness Signature: ____ Date: ___________

Witness Name (print) ____