SILBA Incident Investigation / Near-Miss Investigation Report

Consider using the Root Cause Analysis PROACTIVELY to avoid incidents and near misses.

INCIDENT TYPE | **Date of Incident:**

☐ Fatality	☐ Industrial Non-Recordable	☐ Spill/Leak	☐ General Liability
☐ Lost Workday	☐ Non-Industrial	☐ Product Integrity	☐ Criminal Activity
☐ Restricted Duty	☐ Off-the-Job Injury	☐ Equipment	☐ Notice of Violation
☐ OSHA Medical or Illness w/o LW	☐ Motor Vehicle Collision	☐ Business Interruption	☐ Near Miss
☐ First Aid	☐ Fire		

The investigation of the incident by the employee's supervisor and/or Health and Safety Coordinator must begin immediately. Human Resources and Management must be informed immediately and in no case longer than 24 hours after the incident. This report must be completed as soon as possible. It must be reviewed and signed by the Principal, even if employee is not available to review and sign. Employee or employee's doctor must submit a copy of the doctor's report to Human Resources within 24 hours of the initial exam and any subsequent exams.

EMPLOYER (Include contractors, or other employers on our sites)

Company Name:

Work Location Address where incident occurred: | Project Name:

EMPLOYEE

Name:

Employment Status: ☐ Full-Time ☐ Part-Time ☐ Hourly-As-Needed | How long in present job?

INJURY OR ILLNESS INFO

Where did incident / near miss occur? (number, street, city, state, zip):

On Employer's premises? ☐ Yes ☐ No

Specific activity the employee was engaged in when the incident / near miss occurred:

All equipment, materials, or chemicals the employee was using when the incident / near miss occurred (e.g., the machine employee struck against or which struck employee; the vapor inhaled or material swallowed; what the employee was lifting, pulling, etc.):

Describe the specific injury or illness (e.g., cut, strain, fracture, skin rash, etc.):

Body part(s) affected (e.g., back, left wrist, right eye, etc.):

Name and address of Health Care Provider (e.g., physician or clinic): | Phone No.:

If hospitalized, name and address of hospital: | Phone No.:

Date of injury or onset of illness(MM/DD/YYYY) / / | Time of event or exposure: ☐ AM ☐ PM

Time employee began work: ☐ AM ☐ PM | Did employee lose at least one full shift's work? ☐ No ☐ Yes, 1st date absent (MM/DD/YYYY) / /

Has employee returned to work? ☐ Regular work ☐ Restricted work ☐ No, still off work ☐ Yes, date returned (MM/DD/YYYY) / /

Did employee die? ☐ No ☐ Yes, date (MM/DD/YYYY) / /

Date employer notified of incident / near miss: (MM/DD/YYYY) / /

To whom reported:

Other workers injured/made ill in this event? ☐ Yes ☐ No

Description of Incident / Near Miss: (Describe fully the incident / near miss events. Tell exactly what happened and how it happened so that someone could recreate the incident or near miss. Use extra paper if you need.)

Motor Vehicle Accident (MVA) - You may also have to fill out an insurance form.			Professional Driver? ☐ Yes ☐ No
Total Years Driving:	Company Vehicle? ☐ Yes ☐ No	Operation Type:	Accident Situation:
Truck Transportation:	Years with Carrier:	Vehicle Type:	Equipment #:
Accident Location (street, city, state):			
Hazardous Material? ☐ Yes ☐ No	Reportable? ☐ Yes ☐ No	No. of Vehicles Towed	No. of Injuries: / No. of Fatalities:

Spill/Leak/Product Quality

Product Name		Quantity		Product 2 Name		Quantity		Product 3 Name		Quantity	
Agency Notifications											
Estimated Cost of Incident	$										

Third Party Incidents

Name of Owner		Address		Telephone	
Description of Damage:					
Witness Name		Address		Telephone	
Witness Name		Address		Telephone	

#	**Root Cause and Contributing Factors: Conclusion (Describe in Detail Why Incident / Near Miss Occurred)**
1	
2	
3	
4	
5	

#	Solution(s): How to Prevent Incident / Near Miss From Reoccurring	Person Responsible	Due Date	Closure Date

Investigation Team Members

Name	Job Title	Date

Results of Solution Verification and Validation - after implementing solutions to make sure they work.

Reviewed By

Name	Job Title	Date
	First Line Supervisor	
	Other (name)	