FRED SHEARER & SONS, INC.
ESTABLISHED 1916

Employee Portion Incident Date: _____

Worker Name: _____ Job Site: _____
Day of the week: _____ Time of day: _____ AM ☐ PM ☐
Trade: Carpenter ☐ Taper ☐ Classification: Journeyman ☐ Apprentice ☐
Plasterer ☐ Laborer ☐ Utility ☐
Hod carrier ☐ Sub-contractor ☐

Length of time with FSS: Years _____ Months _____
Length of time on this job: _____ Length of time in the industry: _____

Witness: If none, check this box
Name: _____ Phone: _____ Company: _____
Name: _____ Phone: _____ Company: _____
Name: _____ Phone: _____ Company: _____

Location of incident: _____

Type of Incident		Body Part Affected					
Strain/Sprain	☐	Neck	☐	Wrist/Hand	☐	Knee	☐
Cut	☐	Shoulder	☐	Thigh	☐	Back	☐
Puncture	☐	Elbow	☐	Lower Leg	☐	Hip	☐
Caught between	☐	Forearm	☐	Ankle/Foot	☐	Other	☐
Other	☐	Head	☐	Upper Arm	☐		
Was there a pre-existing condition?		Yes	☐	No	☐		
If yes, describe the condition:							

Equipment used: _____

Incident description:

Employee Signature: _____ Date: _____

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Supervisors Portion

General Contractor: _____ Start time: _____
Overall number of craftsmen on the job site: _____
Number of FSS employees on the job site: _____

Type of Incident	Recordable	☐	First Aid	☐	Near Miss	☐	Property ☐
Type of Shift	Regular	☐	Overtime	☐	After hours	☐	(4) 10's ☐

If there was an urgent care or hospital visit, is an 801 completed: Yes ☐ No ☑
If it was overtime or after hours, describe the situation:

Secure a copy of these items for review					
PTP	☐	Fall Protection Plan	☐	Forklift Checklist	☐
Scaffold Checklist	☐	Aerial Lift Checklist	☐	Stilt Checklist	☐

Was the hazard involved in this incident recognized on the PTP? Yes ☐ No ☑
Did the PTP accurately reflect the scope of the work? Yes ☐ No ☐

What was the exact location of the incident?

Supervisors Narrative:

What was the worker doing yesterday? _____
Was it repetitive? Describe: _____
_____

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Was it overhead work? Yes ☐ No ☐

Chronology of events leading up to the incident:

Time	Action

Current Status:

Supervisor signature: _____ Date: _____
Superintendent signature: _____ Date: _____
Safety committee member: _____ Date: _____

Contributing factors:

Root cause:

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Corrective Action	Responsibility	Due Date	Date Completed

Safety Committee Review Date: _____

List all PPE you were wearing.

- Hard Hat Yes ◯ No ◯
- Safety Glasses Yes ◯ No ◯
- Gloves Yes ◯ No ◯
- Boots Yes ◯ No ◯
- Hearing protection Yes ◯ No ◯
- What cut level of gloves?
- Were you wearing cut sleeves? Yes ◯ No ◯
- Face shield? Yes ◯ No ◯ Mesh ◯ Clear ◯

Did this result in an Eye Injury? Yes ◯ No ◯

What was in the eye?

Did it result in a scratch? Yes ◯ No ◯

Did your glasses fit? Yes ◯ No ◯

If you wear prescription safety glasses, were you wearing side shields?

Yes ◯ No ◯

Explain the task in detail, include tools used.

How was your body positioned in relationship to the work?

Were you twisting your body? Yes ◯ No ◯

- Were you reaching? Yes ◯ No ◯
  - Up ☐
  - Down ☐
  - Sideways ☐

Were you working close to your face? Yes ◯ No ◯

If yes, describe the work.

Mark the eye effected on the diagram below.

Did this result in a Slip or a Trip? Yes ◯ No ◯

Was the ground uneven? Yes ◯ No ◯

What caused the slip or trip?

Were you carrying anything? Yes ◯ No ◯

What were you carrying?

What boots were you wearing?

Were they laced? Yes ◯ No ◯

Were there open holes? Yes ◯ No ◯

Did this result in a Strain or Sprain? Yes ◉ No ◯

Were you overreaching to get to your work? Yes ◯ No ◯

Was there a problem getting closer to your work? Yes ◯ No ◯

Was your work planned? Yes ◯ No ◯

Were you working overhead? Yes ◯ No ◯

Were you bending or pulling? Yes ◯ No ◯

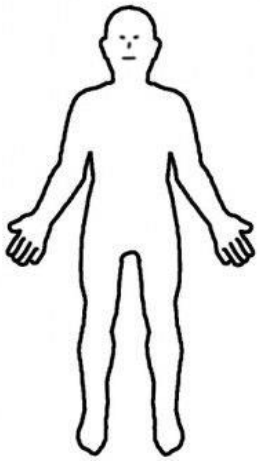
Were you lifting a heavy load? Yes ◯ No ◯

Were you twisting your body?	Yes ◯	No ◯
Were you warmed up before you did your work?	Yes ◯	No ◯
Did you walk your work area before you started?	Yes ◯	No ◯
Was it clear and free of debris?	Yes ◯	No ◯
Was the lighting adequate?	Yes ◯	No ◯

Did in a Cut or Abrasion?

Were you wearing gloves?	Yes ◯	No ◯
Were you wearing cut sleaves?	Yes ◯	No ◯
Were you working with sharp material?	Yes ◯	No ◯
Was it identified on your PTP?	Yes ◯	No ◯

Mark the drawing below to show where the injury was.



Tools and Materials

What material was used?

What tool(s) were used?

Did you have all the tools you needed to complete your task successfully?

Yes ◯ No ◯

What attachments were on the tool(s)?

If a vacuum, was it working properly Yes ◯ No ◯

How often was the filter cleaned?

Did the tool need side handles? Yes ◯ No ◯

Did it have them? Yes ◯ No ◯

Did the task generate flying debris? Yes ◯ No ◯

If there were sparks, where were they directed?

What equipment was used to access your work?

- MEWP ◯
- Baker ◯
- Step up ◯
- Ladder ◯
- Roll and fold ◯
- Stilts ◯
- Scaffold ◯

Work Location.

- Where exactly on the job were you?
    - What floor
    - Area in the building or on the site N, E, S, W
    - Indoors

- Outdoors

- Exterior work
  - What was the weather?
    - Windy ◯
    - Sunny ◯
    - Wet ◯
    - Icy ◯
    - Hot ◯
    - Cold ◯
- Interior work
  - Lighting Good ◯ Poor ◯
  - Housekeeping Good ◯ Poor ◯
  - Material storage Good ◯ Poor ◯
  - Debris Good ◯ Poor ◯

What was around you?

- Mono Kote Yes ◯ No ◯
- Ceiling wires Yes ◯ No ◯
- Mechanical Yes ◯ No ◯
- Electrical Yes ◯ No ◯
- Plumbing Yes ◯ No ◯
- Other trades Yes ◯ No ◯
- Were you hanging sheet rock? Yes ◯ No ◯
  - What kind of board?
  - What length?
- Were you framing? Yes ◯ No ◯
  - What gauge of material?
  - What length of material?
  - Radius? Yes ◯ No ◯

Were you using a PAF?	Yes ◯	No ◯
Did you have ear protection?	Yes ◯	No ◯

General Information

Did you participate in stretch and flex?	Yes ◯	No ◯
Did you follow company approved stretch and flex?	Yes ◯	No ◯
Were you driving any equipment?	Yes ◯	No ◯
Truck	Yes ◯	No ◯
Forklift	Yes ◯	No ◯
Rough terrain forklift	Yes ◯	No ◯
Aerial Lift	Yes ◯	No ◯
MEWP	Yes ◯	No ◯
Did you rig a load?	Yes ◯	No ◯
Are you current on training certificates?	Yes ◯	No ◯

Additional Notes: