FIELD ACCIDENT REPORT

This Report is to be filled out by the designated Safety Officer After EVERY accident, and forwarded to the Central Office for processing.

PROJECT NAME ______________________________ PROJ. NUMBER ______________

Date of Accident ___________________________ Reported By ________________

Type of Accident (Check One):

( ) Vehicular ( ) Personal ( ) Other

Name of Injured _____________________________ Date of Birth or Age ___________

How Long Employed __________________________

Names of Witnesses ____

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Did the Injured Lose any Time? ____________ How Much (Days/Hours)? ________

Was Safety Equipment in use at the time of the Accident (Hard Hat, Safety Glasses, Gloves, Safety Shoes, etc.)? ____

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(If not, it is the EMPLOYEE'S sole responsibility to process his/her claim through his/her Health and Welfare Fund.)

DESCRIPTION OF THE ACCIDENT ____

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ACTION TAKEN: ____

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INDICATE STREET NAMES, DESCRIPTION OF VEHICLES, AND NORTH ARROW

Company Driver/Operator	Other Driver/Operator
Insurance Carrier ______________	Insurance Carrier ______________
Driver Name ______________	Driver Name ______________
Address ______________	Address ______________
______________	______________
Operator License No. ______________	Operator License No. ______________
Vehicle License No. ______________	Vehicle License No. ______________
Owner Name ______________	Owner Name ______________