Incident Report

Employee Making Report

Name: Position: Contact No:

Incident Details

Date of incident: Time: Date Reported: Time:

Supervisors Name: Time lost (to date): Time lost (anticipated overall):

Medical Treatment required if applicable:

Type and details of the incident				
Type of incident	☐ **CoR Breach**	☐ **Vehicle accident**	☐ **HSE**	☐ **Near miss**
	☐ Fatigue	☐ Single Vehicle Collision	☐ Trip/Slip	Define:
	☐ Mass/Dimension	☐ Multi Vehicle Collision	☐ Fall from height	
	☐ Load restraint	☐ Other	☐ Chemical Spill	
	☐ Speed	Define:	☐ Impact	
	☐ Maintenance		☐ Confined spaces	
	☐ Dangerous Goods		☐ Health related issues	
			☐ COVID-19/Test/Symptoms/Close Contact/etc	
			☐ Other	
			Define:	

Describe the events leading up to the incident and how it occurred

Describe what action was taken

Describe the consequences/potential consequences of the incident

Remarks and policy/SOP references

Signature: Date: