

# Incident Reporting Form



<b>Incident Description</b>			
Incident Involved? <input type="checkbox"/> Person <input type="checkbox"/> Property Damage, see <a href="#">Property Damage Reporting Form</a>			Date of Report
Has the SCA Been Notified? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, to whom and by what method?			
Project/School Name		School Address	
Borough		SCA Contract Number	
Date of Incident	Time <input type="checkbox"/> AM <input type="checkbox"/> PM	OCIP WC Policy Number	

<b>Person Involved in the Incident</b>			
Name of Person Involved		Phone Number	Job Title
Address of Person Involved		Date of Birth	SSN
Employer		Supervisor Name & Phone Number	
Person Involved? <input type="checkbox"/> Contractor <input type="checkbox"/> Vendor <input type="checkbox"/> Pedestrian <input type="checkbox"/> DOE Employee <input type="checkbox"/> Student <input type="checkbox"/> Other:			
Safety Training? <input type="checkbox"/> 10 Hour OSHA <input type="checkbox"/> 30 Hour OSHA <input type="checkbox"/> 40 Hour SST <input type="checkbox"/> 62 Hour SST <input type="checkbox"/> Safety Orientation <input type="checkbox"/> Scaffold <input type="checkbox"/> Other:			
Exact Location of Incident		Has the Location Been Secured? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Did the Incident Involve Equipment? <input type="checkbox"/> Yes <input type="checkbox"/> No		Has the Equipment Been Secured? <input type="checkbox"/> Yes <input type="checkbox"/> No	
If yes, what type of equipment? Include Make/Model/Serial Number			
If Equipment was secured, who has it? (Name, Company & Phone)			
Was the person involved person wearing PPE? <input type="checkbox"/> Yes <input type="checkbox"/> No			
If yes, what type?			

<b>Incident Description</b>
Involved person's statement of how the incident occurred, including the tasks being performed and specifics regarding equipment, structure, tools, materials, objects, positions, distances and sequence of events.

*The above has been translated, if and as necessary.*

Involved Party Signature	Date
--------------------------	------

<b>Other Information</b>	
<b>Name of Person Involved</b>	<b>Union Member?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, which one? Include Local Number.
<b>Employer Name &amp; Address</b>	<b>Employee Status?</b> <input type="checkbox"/> Regular Full-Time <input type="checkbox"/> Regular Part-Time <input type="checkbox"/> Seasonal <input type="checkbox"/> Temporary
<b>Did the person involved seek Medical Attention?</b> <input type="checkbox"/> Yes <input type="checkbox"/> First Aid Only <input type="checkbox"/> No If yes, where?	
<b>Were Emergency Services Called?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No	
<input type="checkbox"/> <b>NYPD</b> Which Precinct?	<input type="checkbox"/> <b>EMS/Ambulance</b> Which Hospital?
<input type="checkbox"/> <b>FDNY</b> Which Department?	
<b>Nature of Reported Injury</b>	
<b>Months with Employer/Date Hired?</b>	<b>Months Doing This Job?</b>

<b>Witness Contact Information</b>			
<b>Witness Name &amp; Employer</b>	<b>Home address</b>	<b>Phone</b>	<b>Email</b>

<b>Preparer Information</b>			
<b>Name of individual who prepared report</b>		<b>Employer</b>	
<b>Phone</b>	<b>Email</b>	<b>Signature</b>	<b>Date Signed</b>

EMAIL FORM TO: [noticeofaccident@nycsca.org](mailto:noticeofaccident@nycsca.org)  
For URGENT matters call: (718) 472-8778

The above has been translated, if and as necessary.

<b>Involved Party Signature</b>	<b>Date</b>
---------------------------------	-------------