UPPER MERION TOWNSHIP
Incident Report

NAME _____ JOB TITLE _____
if employee incident

ADDRESS _____ DATE OF INCIDENT _____

_____ TIME OF INCIDENT _____

_____ STARTING TIME _____
(street, city, zip)

TELEPHONE _____ | _____ TYPE _____ | _____ | _____
area code | number — employee | emergency responder | visitor

INJURIES? _____ yes _____ no

SUPERVISOR NOTIFIED _____

_____ | _____ LOST TIME? _____ yes _____ no
date | time

☐ *Check here if this could result in an insurance claim*

If injured party is employee of Upper Merion, please provide:

Date of hire: _____

Married ? _____ | _____ No. of Dependents _____
Yes | No

_____ _____
Name of person filling out report — date

_____
address

_____
phone

0
Name of Department Head notified

0-Jan-00 | 0
Date | Time
Department Head notified

copies to: **department head**
Vicchio
Kraynik
Tracy
Waters
Santoro / Evans

Preferred method of transmission is e-mail. When e-mailed, the indicated personnel receive it automatically; only the department head needs to be e-mailed separately.

email to: irsubmit@umtownship.org

revised: ***6/16/2010***

DATE OF INCIDENT 0-Jan-1900

EXACT LOCATION OF INCIDENT:

DESCRIPTION OF THE INCIDENT: (who, what, when, where, why, how) Use additional Sheet(s) if necessary.

CAUSES AND CONTRIBUTING FACTORS:

RECOMMENDATIONS:

ACTION TAKEN:

WITNESSES OR PEOPLE FAMILIAR WITH THE INCIDENT:

name	address

IF INJURIES INVOLVED, DESCRIPTION OF INJURIES & WHERE TREATMENT WAS SOUGHT:

Below space for Safety Committee Use Only

WAS INCIDENT REPORT REVIEWED BY WORK PLACE SAFETY COMMITTEE? Yes No

***ROOT CAUSE OF INCIDENT AND RECOMMENDATIONS OF SAFETY COMMITTEE*:**