

Contractor Incident Notification Form



The Contractor shall immediately notify the appropriate NiSource Representative of any Incident with a verbal notification. This form shall be completed and returned, within 48 hours of the incident, to the applicable NiSource Safety Representative. Fill out all applicable form fields. Be as specific as possible; attach the pre-job briefing and any additional narrative as needed.

INJURY

INCIDENT WITHOUT INJURY

CONTRACTOR COMPANY NAME

Station/Project Name:

STATION/PROJECT NAME

PROJECT ADDRESS

LOCATION OF INCIDENT

Closest Exact Address or GPS Coordinates

JOB # / WORK ORDER # (If Applicable)

DATE OF INCIDENT

TIME OF INCIDENT

TIME EMPLOYEE BEGAN WORK

SUPERVISOR NAME

SUPERVISOR PHONE NUMBER

SUPERVISOR EMAIL

NO INJURY If no injury, check box and skip boxes outlined in red

SUBCONTRACTOR INVOLVED?

If yes, complete boxes outlined in green.

INJURED EMPLOYEE JOB TITLE

SUBCONTRACTOR COMPANY NAME

SUBCONTRACTOR SUPERVISOR NAME

SUBCONTRACTOR SUPERVISOR PHONE NUMBER

SUBCONTRACTOR SUPERVISOR EMAIL

NATURE OF INJURY/ILLNESS

WAS THERE A PREJOB BRIEFING?

WERE HAZARDS SUFFICIENTLY IDENTIFIED ON THE PRE JOB BRIEFING?

IF OTHER, EXPLAIN

DESCRIBE WHAT HAPPENED (1000 Characters)

TREATMENT TYPE

BODY PART(S) INJURED

NAME OF MEDICAL FACILITY

ADDRESS OF MEDICAL FACILITY

OBJECT THAT CAUSED HARM

IMMEDIATE ACTIONS TAKEN (1000 Characters)

FORM COMPLETED BY

CONTACT INFORMATION