

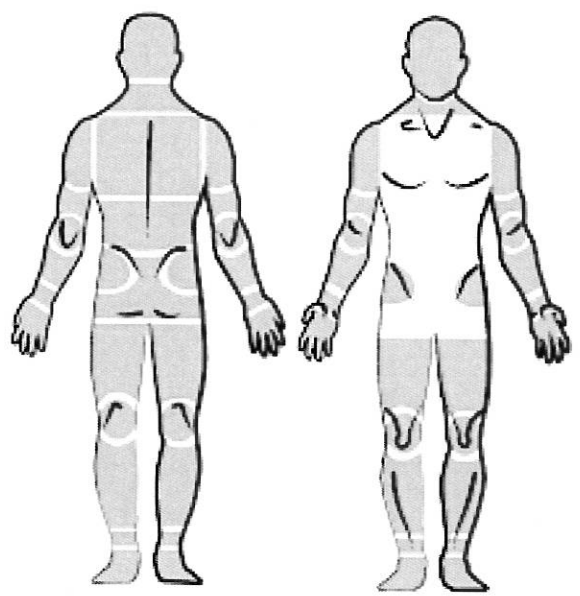
**O'NEILS PERSONNEL  
ACCIDENT/INCIDENT REPORT**

**Step 1: INJURED / AFFECTED PERSON TO COMPLETE**

Date of incident		Time of incident	AM/PM
Name of Employee			
Phone Number(s)			
Address Injury took place			

Injury Type (Tick as many as required) and circle/shade part of body injured

- Pain / Discomfort
- Strain / Sprain
- Broken bone
- Cut
- Vehicle Incident
- Equipment / Tooling Incident
- Property damage



Treatment	<input type="checkbox"/> None	<input type="checkbox"/> First Aid	<input type="checkbox"/> Medical Treatment-Dr	<input type="checkbox"/> Medical Treatment-Hospital
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What happened?

Was the injury work related?	(Circle) Yes No
Medical attention desired/required	(Circle) Yes No
Name of physician/hospital	
Physician/hospital address	
Physician/hospital phone number	
Injured / Affected Person's Signature	Date