Property Cost Est. $ ___________

SAFETY INCENTIVE DISQUALIFICATION: ☐ Yes ☐ No ■ Individual ☐ Team ☐

Accident/ Incident /Injury/Near Miss - Reporting Form

☐ ALL STATES ASPHALT, INC. ☐ WARNER BROS., LLC. ☐ TREW STONE, LLC. ☐ NEW ENGLAND EMULSIONS CORP.
☐ KILLINGLY ASPHALT, LLC. ☐ JOHNSTON ASPHALT, LLC. ☐ TRI PRODUCTS, LLC. ☐ W.T. Terminal, LLC. AUBURN ASPHALT, LLC

THIS FORM **MUST** BE FILLED OUT COMPLETELY FOR **ALL** ACCIDENTS/INCIDENTS/INJURIES/NEAR MISSES

REPORTING GUIDELINES

- ☐ CALL 911 TO REPORT CRASH AND EMERGENCY MEDICAL SERVICES (EMS) IF NEEDED
- ☐ TAKE STEPS TO PROVIDE SCENE SAFETY PENDING ARRIVAL OF RESPONDING PERSONNEL (CONES, REFLECTORS, and FLAGS)
- ☐ PROVIDE FIRST AID IN ACCORDANCE WITH TRAINING AND QUALIFICATIONS
- ☐ TAKE STEPS TO REMEDIATE SPILL IF POSSIBLE
  - ☐ FOR SPILLS 10 GALLONS OR LESS, USE ISSUED SPILL KIT TO CONTAIN THE SPILL AS MUCH AS POSSIBLE, KEEPING MATERIAL AWAY FROM STORM DRAINS AND STANDING WATER
  - ☐ FOR SPILLS IN EXCESS OF 10 GALLONS, ALSO TAKE STEPS TO PROTECT THE PUBLIC, KEEPING BYSTANDERS DOWN WIND AND FLAMMABLE MATERIALS AWAY FROM SPILL
- ☐ CALL DISPATCH @ **413 665-7051**, IF NO ANSWER CALL 866.317.1593
- ☐ IF ABLE, GATHER NAMES, LICENSE NUMBERS AND CONTACT INFORMATION OF OTHER DRIVERS AND WITNESSES, LOG WHERE APPROPRIATE ON THIS FORM
- ☐ BE POLITE AND NON-OPINIONATED. **NEVER ADMIT FAULT OR RESPONSIBILITY FOR THE INCIDENT**
- ☐ **DO NOT** TALK WITH NEWS MEDIA
- ☐ COMPLETE APPROPRIATE SECTIONS ON THIS FORM, **THEN TURN IN TO YOUR SUPERVISOR**
- ☐ SUPERVISOR IS TO CONDUCT INVESTIGATION, COMPLETE REPORT AND SUBMIT TO HR MANAGER, BY END OF DAY.

BASIC

Employee's Name (Last, First, MI):	Home Telephone Number:	Date of Birth:	Date of Hire:
Address:	City:	State:	Zip:
Date of Accident/Incident/Injury (mm/dd/yyyy):	Time:	Supervisor:	
Location:	Safety program followed? ☐ Yes ☐ No	Date Reported:	
Weather Condition:	List safety equipment in use:		
Accident/Incident/Injury/Near Miss result of: ☐ unsafe behavior ☐ unsafe condition	Did this involve material spill: ☐ Yes ☐ No	If yes, what material:	

(1.) EMPLOYEE INJURY

Briefly Describe Injury (how it happened and what was injured):	
Witness(es) to Injury - Please give full names:	Source of Injury (chemicals, machinery, etc.):
	Person to Whom Injury was Reported (list title):

I authorize the release of medical information and facts regarding this injury, including reports and records, results or diagnosis, treatment and prognosis, estimates of disability and recommendations for further treatment relating to this injury. This information is to be used for the purpose of evaluating and handling my claim for injury as result of an accident occurring on or about ____________________ and for no other purpose, now or in the future.

______________________________ ______________________
Employee Signature Date

I was offered medical treatment at this time and I have declined.

______________________________ ______________________
Employee Signature Date

Continued on Reverse

(2.) PROPERTY and/or EQUIP

Company Vehicle Driver:	Destination:	Driver License #:	
Vehicle/Equipment/Trailer Make & Model:	VIN#:	License Plate #:	
Owned By/Leased From:	Dispatch Terminal – Departure Time:	Equipment Number:	
Police Department: State: Case Number:	Officer Name: Badge #:	Citation: ☐Yes ☐No	Charge:
Accident/Incident Description (use additional sheets if necessary- describe damage to vehicles):			

Witnesses - use additional sheets if necessary

Name:	Address City State Zip	Phone:
Name:	Address City State Zip	Phone:

Vehicle #2 Information:

Driver:	Driver License #:	Injured: ☐Yes ☐No	Phone:
Address: City State Zip		License Plate # & State:	
Owner (If not Driver):	Vehicle Make & Model:		
Address: City State Zip			

Passengers - use additional sheets if necessary

Name:	Address City State Zip	Injured: ☐Yes ☐No
Name:	Address City State Zip	Injured: ☐Yes ☐No

SIGNATURE

CORRECTIVE ACTIONS - describe how accident/incident/injury/near miss could have been avoided:

______________________________ ______________
Employee Signature **Date**

______________________________ ______________
Supervisor Signature **Date**

This report must be completely filled out and submitted to the H.R. Manager by the end of the day. Incomplete or late reports will result in a disqualification from the Safety Incentive Program for 90-days and possible discipline.

OFFICE

Reportable to Insurance Company: __ Yes __ No Date Reported: Time:	Claim Number Assigned:	Claim Rep. Name:
Lost time injury: Yes No Date Became Lost Time:	Date Safety Log Updated:	Claim Rep. Contact:
OSHA Recordable: __Yes __ No Date Recorded on OSHA Log:	Type: __ APD __ AL __ WC __ Property	EE SSN: