All States Materials Group

Safety, Quality, Production...In That Order!

Please complete this form for any incident, accident, injury or near miss. The Safety Department will follow up with all involved parties to finalize the investigation.

Please Note: We have light duty work available and will accommodate

Select company associated with incident:

- ☐ 01-ASC
- ☐ 06-Killingly
- ☐ 07-Johnston
- ☐ 15-Trew Stone
- ☐ 16-Warner Bros
- ☐ 17-WT Terminal (Deerfield)
- ☐ 18-Management Group
- ☐ 20-Auburn
- ☐ 21-Down East
- ☐ 23-NEE
- ☐ 27-Carroll
- ☐ 29-ASA
- ☐ 30-Mitchel
- ☐ 31-WT Terminal (Oswego)
- ☐ 35-ASMG Services
- ☐ 36-WT Terminal (Providence)
- ☐ 37-All States Emulsions

Enter Your Full Name (First & Last):

Enter your phone #:

Are you the direct supervisor of employee(s) Involved?

○ Yes ○ No

Direct Supervisor Name (If not you):

Incident Location:

Date of Incident:

Location of Incident

Other Location:

Job Detail (Location & Job #):

Road(s) or Intersection(s):

State:

Please note the specific area of the work zone or facility where the incident occurred. Include descriptive items such as mile markers, landmarks, signage, etc.

Was proper PPE being worn by involved person(s) at time of incident?

☐ Yes ☐ No

Were All Safety Policies Followed? If "No", elaborate in Incident Detail section below.

☐ Yes ☐ No

Incident Detail:

Provide an overview of the incident, including any factors that might have contributed.

Incident Type:

Incident Type(s)

Other:

Person(s) involved:

First and Last Name	Relationship to ASMG	Employee ID (if employee)	Medical Attention Needed?	Injury Type	Injury Type (Other)

Injury Details:

Were any of the above employees taken to a medical facility?

○ Yes ○ No

Were any of the above employees treated in an emergency room?

○ Yes ○ No

If any of the employees above were taken to a medical facility or emergency room, and you have access to that information at the time of completing this incident form, please complete the fields below. Follow the order in which the employees were entered above for the treatment facilities they were taken to.

Medical Facility Name:

Physician Name:

Phone:

City:

State:

Zip Code:

Medical Facility Name:

Physician Name:

Phone:

City:

State:

Zip Code:

Medical Facility Name:

Physician Name:

Phone:

City:

State:

Zip Code:

ASMG Equipment And Property: EQ# Required for any incidents involving ASMG Equipment

Equipment 1 (#)

Equip Description 1

Damage Detail 1

Equipment 2 (#)

Equip Description 2

Damage Detail 2

Equipment 3 (#)

Equip Description 3

Damage Detail 3

Non ASMG Equipment & Property:

Was Non-ASMG equipment or property damaged?

○ Yes ○ No

If Yes, was a police report obtained?

○ Yes ○ No

Police Report #

Non-ASMG Equipment

Vehicle Year	Vehicle Make	Vehicle Model/Description	Vehicle VIN	Detail Damage

If there was damage to physical property, describe below:

Non-ASMG Contacts:

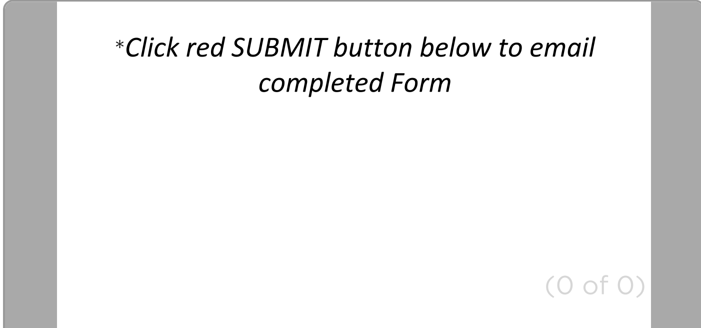
Non-ASMG Contacts and/or Witness Information

First and Last Name	Phone Number	Email	Street Address, City, State

Provide Additional Contact Information Here (If Needed):

Summary (Note steps taken after incident):

Please attach photos of the incident including: damage to ASMG and Non-ASMG equipment, work zone, scene, facility, etc. as well as any other documents pertaining to the incident.



By signing and submitting this form, you acknowledge the information provided is honest and factual.

Signature: ***Place Digital Signature Below***

Name:

Date:

Form Filler:

Created On:

Form ID: