Property Management HSSE
Initial Incident Report

Instructions: The Initial Incident Report should be completed using this form (or an equivalent form) or provide similar information in an e-mail note.

Report Date: _____

Location / Building: _____

Date / Time Occurred: _____

Date / Time Reported: _____

_____

Event Description: _____

_____

_____

Number and types of injuries if any: _____

_____

_____

Immediate Action Taken: _____

_____

Corrective Action Taken: _____

_____

Company involved (if applicable): _____

Completed by: _____

This report is to be completed when injury or incident occurs. If a member is injured or develops an exercise related illness as a result of his/her participation at the BP wellness Center, s/he must complete and submit the "Incident Report". If the member is unable to complete the form, the attending Wellness Center staff person must complete on his/her behalf.

Please complete each section. If you have any questions, please call 281-366-5109 or e-mail: sharemsm@bp.com

Incident Reporting ensures there is a record on file. If an injury occurs, first aid may be appropriate treatment.

BP Wellness Center
INCIDENT REPORT

MEMBER INFORMATION:				
Campus Location:	BP Westlake Campus			
Employee's Name (PRINT):		Sex:	☐ Male	☐ Female
Work Address:		Work Phone:		
Business Unit:		Job Title:		

INCIDENT INFORMATION					
Date of Incident:		Time of Incident:		☐ a.m.	☐ p.m.
Location of Incident:					
State all parts of body and type of injuries involved(e.g. bruised right elbow):					
Describe how incident occurred:					
Was incident reported?	☐ Yes	☐ No	If "yes" to whom:		
Date reported:		Wellness Staff reporting:			
Were there witnesses?	☐ Yes	☐ No	☐ Unknown		
Name of Witness #1 (First and Last):					
Witnesses #1 Phone:					
Name of Witness #2 (First and Last):					
Witnesses #2 Phone:					
Is this a new injury?	☐ Yes	☐ No	If "no", please indicate the date of original injury:		

INITIAL FIRST AID/MEDICAL TEATMENT:				
Was treatment or first aid received/needed for this injury?				
☐ No medical treatment – reporting only	☐ Declining treatment at this time	☐ Treatment was/will be provided		
Treatment/First Aid was provided by:	☐ Self	☐ Wellness Staff	☐ Emergency Room	☐ Other (please specify below)

If treatment was provided, please describe:			
I, the injured member, herein certify the information above is true and to best of my knowledge.			
Date:		Signature of Employee:	

WELLNESS SUPERVISOR COMPLETES THIS SECTION:					
Supervisor Name :					
Work Phone:			Work e-mail address:		
Describe how the member was injured?					
Was there equipment involved?	☐ Yes	☐ No	If “yes”, what was the equipment?		
What action will be taken to prevent recurrence?					
Other comments:					
Date:		Signature:		Title:	