UTP Productions accident checklist

☐ **Provide first aid** if a trained person is available.

☐ If the injury is an emergency, then please call 911. Otherwise, **call UTP's dedicated injury hotline at (801)209-9193. You will be guided through the process.** If there is no answer, please leave a detailed message of the injury. Please provide contact information including a phone number so we can return your call as soon as possible. This number is available 24/7/365.

☐ **The employee, supervisor and witnesses must fill out the necessary reports.** This can be accomplished at **utpproductions.com** for your easiest solution. The forms may also be printed and either emailed or faxed to us. This includes incidents that may not require immediate medical attention. **All reports must be received within 24 hours of the incident.**

☐ **Investigate the accident scene – provide detailed description of accident and equipment involved. Pictures may also be taken with a cell phone and sent via text message to (801)209-9193.**

☐ **Any accidents/incidents that involve death, amputation, loss of an eye or inpatient hospitalization require that the scene be preserved per OSHA requirements!**

☐ Other important contact information:
UTP Productions Phone: 801 328-1298
Fax: 801-328-1307
email: workcomp@utpgroup.com

Instructions: Employees shall use this form to report all work related injuries, illnesses, or "near miss" events (which could have caused an injury or illness) – *no matter how minor.* This helps us to identify and correct hazards before they cause serious injuries. This form shall be completed by the employee as soon as possible and given to a supervisor to forward to UTP for review.

Employee Accident Report

Employee Name:	Date of Birth: / /
Last First Middle	

Home Address	SSN: — —

City	State, Zip Code	Phone #

ACCIDENT INFORMATION

Time shift began: Time shift was to end:	Date of accident: Time of accident: Time accident reported to supervisor:	
Venue: Area of accident (ie dock, stage):	Will you be missing the remaining days on the call?	Will you be missing/declining future calls?
Describe how the accident occurred: (Please be as specific as possible)		
Describe bodily injury sustained: (Please be as specific as possible)		
Did you receive first aid on site?	What first aid treatment did you receive?	Who administered treatment?
Recommendation on how to prevent this injury from recurring:		

Have you previously filed a work comp claim (not including today)?	Body part affected:	Date of claim:
Name of Supervisor:		
Name of any witnesses to today's incident:		
Employee signature:		Date:

ONCE FORM IS COMPLETED FAX TO: (801)328-1307 or E-MAIL: julie@utpgroup.com

Instructions: Please refer to the accident checklist for step by step instructions on how to handle and injury/illness on a job site. **Please fill this form out in its entirety. There is information on this form that I cannot get elsewhere for the OSHA Log requirements.** Thank you for your assistance.

Supervisor's Accident Report

Location where accident occurred: (ie dock or stage etc) Was injury promptly reported?	Venue: Load in date: Load out date:	Date of accident: Time of accident: am ☐ pm ☐
Who was injured?	Was first aid provided? By whom? Phone #	Time shift began: Time shift was to end:
What was employee doing when injury/illness occurred?		
How did injury occur? (Please be as specific as possible)		
Why did it happen?		

Part of body affected/injured: Any prior physical conditions?	What equipment was involved and/or damaged?
Nature and extent of injuries: (Please be as specific as possible)	

PLEASE INDICATE ALL OF THE FOLLOWING WHICH CONTRIBUTED TO THE INJURY OR ILLNESS

___ Failure to lockout	___ Improper maintenance	___ Poor Housekeeping
___ Failure to secure	___ Improper protective equipment	___ Poor Ventilation
___ Horseplay	___ Inoperative safety device	___ Unsafe arrangement or process
___ Improper dress	___ Lack of training or skill	___ Unsafe equipment
___ Improper guarding	___ Operating without authority	___ Unsafe Position
___ Improper instruction	___ Physical or mental impairment	___ Other
What should be done to ensure this type of accident does not recur:		

Supervisors Name	Supervisors Signature	Phone #	Date

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Accident Witness Statement

Your Name:	Phone #:	Date:
Your Address:		
Who was injured/involved in the incident:		
Describe fully how accident occurred: (Please be as specific as possible)		
Signature:		

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If you fill this out at our website; (utpgroup.com) it will be emailed to me when you click submit.

Accident Witness Statement

Your Name:	Phone #:	Date:
Your Address:		
Who was injured/involved in the incident:		
Describe fully how accident occurred: (Please be as specific as possible)		
Signature:		

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Accident Witness Statement

Your Name:	Phone #:	Date:
Your Address:		
Who was injured/involved in the incident:		
Describe fully how accident occurred: (Please be as specific as possible)		
Signature:		

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