Incident/Accident Report

SONOCO
Sontheimer Offshore/catering Co.

Safety and Environmental Management System		SMS F300

(Check Job Title of Injured) _____Utility Hand _____Night Cook ___Steward/Relief ___Warehouse ____Driver

Injured:
Name (FML): _____ SS#:_____

Address:_____ City: _____ ST:____

Zip Code:_____ Phone Number: (_____)_____ DOB:_____ Age:_____

Date of Hire:_____ Date of Injury:_____ Time:_____

Time Shift Began:_____ # of Days on Location:_____ Employee SSE?_____

Facility:
Customer:_____ Block & Field Location:_____

Where on facility did accident occur:_____(Galley, Quarters, etc.)

Incident Details:
Accident happened _____/_____/_____ @ _____ AM/PM

Nature of Injury: _____ (Cut, Fall, etc.)

Did employee stop work immediately? _____ Injury on SONOCO Property:_____

Did injury cause lost time beyond shift?_____ # Days: _____ Did injury cause death?_____

Reported to Customer/Medic:_____/_____/_____ Time:_____ to who?_____

Reported to SONOCO Office: :_____/_____/_____ Time:_____ _ to who?_____

Witness 1 Name_____ Phone #_____ Company:_____

Witness 2 Name_____ Phone #_____ Company:_____

Witness 3 Name_____ Phone #_____ Company:_____

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Describe the incident including as many details as possible:

What Happened?_____

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Was Medical Attention/First Aid given on-site?_____ By Who?_____ Employee sent in:_____

What care was given?_____

Corrective Action:

All PPE worn/used properly?_____ Why Not?_____

Immediate Corrective Action Taken:_____

By Who? _____ Safety Meeting Held to Discuss: ____/____/____ @_____

Date of Report _____/_____/_____ By: _____ Position:_____

Signature_____ Fax to (985) 872-2251 or email to safety@sontheimeroffshore.com