



INTERNATIONAL BROTHERHOOD OF TEAMSTERS

WORKPLACE FATALITY REPORT - 2019

Please complete this report in the event of an on-the-job death, in the previous year to the present.

Date occurred _____ Time occurred _____

Information about Deceased:

Name: _____ Job Class/Title _____
Social Security Number _____ Local Union Number _____

Information about Company:

Company Name _____
Address _____
City _____ State(Province) _____
Zip Code _____
Type of Industry _____
Bargaining Unit Size at company _____

Reported By:

Name _____
Title _____

Cause of Death: (pick one)

- | | |
|---|---|
| <input type="checkbox"/> Electrical | <input type="checkbox"/> Inhalation of gas, specify _____ |
| <input type="checkbox"/> Elevator/hoist conveyor | <input type="checkbox"/> Stepped on |
| <input type="checkbox"/> Explosive | <input type="checkbox"/> Struck by: |
| <input type="checkbox"/> Fall | <input type="checkbox"/> Vehicle |
| <input type="checkbox"/> Fire | <input type="checkbox"/> Machine |
| <input type="checkbox"/> Hand tool | <input type="checkbox"/> Object |
| <input type="checkbox"/> Handling objects, manual | <input type="checkbox"/> Other, specify _____ |
| <input type="checkbox"/> Heat | <input type="checkbox"/> Striking against object |
| <input type="checkbox"/> Poisoning | <input type="checkbox"/> Vehicular accident: |
| <input type="checkbox"/> Other, specify _____ | <input type="checkbox"/> Local Pickup & Delivery |
| _____ | <input type="checkbox"/> Over-the-road |
| _____ | <input type="checkbox"/> Powered industrial truck |
| _____ | <input type="checkbox"/> Other, specify _____ |
| | <input type="checkbox"/> Workplace Violence |
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Notes: (Please provide details of the incident)

PLEASE MAIL OR FAX TO:
IBT Safety and Health Department
25 Louisiana Ave, NW, Washington, DC 20001
(202) 624-6960 Phone (202) 624-8740 Fax