



EMPLOYEE INCIDENT REPORT

PART ONE – EMPLOYEE’S REPORT

EMPLOYEE TO COMPLETE

Employee complete Part 1 and sign the bottom of the form. Submit the form to your Manager/Supervisor immediately after your incident. If you seek HEALTH CARE OR experience LOST TIME, speak directly to your Manager or their delegate who will make every attempt to offer suitable modified work.

Last Name : _____ First Name: _____ Date of Birth: _____
 Address: _____ Postal Code: _____ SIN# _____
 Occupation: _____ Full Time Part Time Casual Years of Experience: _____
 Date of incident: _____ Time of Day: _____ Home Phone: _____
 Date incident reported: _____ Time of Day: _____ Work Extension: _____
 Location of incident: _____ Department: _____
 Manager’s Name: _____ Who reported to: _____

Description of Incident (Explain how incident occurred, equipment used including sizes, weight, etc.)

Describe Injury and All Parts of the Body Involved (specify Left or Right)

Type of Incident

Struck or contacted by Caught in/on/between Struck against Slip/trip/fall Overexertion/Strain
 Repetitive Action Violence/Harassment Exposure Patient Action Other: _____

Nature of Injury

Abrasion Laceration Fracture Contusion/Bruising Strain/Pull Strain/Twist
 Burn Amputation Cardiac Arrest Respiratory Crushing Seizure
 Loss of Consciousness Hearing Loss/Impairment Other: _____

Reminder: If you plan to seek medical attention related to this incident, please update Human Resources at ext. 5581 with the name of the Health Care Provider you are seeing and your appointment date.

NAME OF WITNESSES TO OR PERSONS HAVING KNOWLEDGE OF INCIDENT : _____

EMPLOYEE SIGNATURE: _____

This form faxed to Human Resources by : _____ Name _____ Date _____



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MANAGER/SUPERVISOR TO COMPLETE	PART TWO – MANAGER/SUPERVISOR’S INVESTIGATION (FOLLOW UP) REPORT		
	Manager/Supervisor completes Part 2 (within 48 hours) once the employee has completed Part 1 and ensures both forms are faxed to Human Resources 759-5565 immediately as WSIB information must be sent within 3 days.		
	<input type="checkbox"/> NO INJURY <input type="checkbox"/> FIRST AID <input type="checkbox"/> HEALTH CARE <input type="checkbox"/> LOST TIME <input type="checkbox"/> CRITICAL INJURY		
	LAST NAME		FIRST NAME
	DEPARTMENT		MANAGER
	DATE OF INCIDENT	DATE REPORTED	LOCATION WHERE INJURY OCCURRED
	WHAT CONDITION(S) CONTRIBUTED TO THE INCIDENT		
	<input type="checkbox"/> PEOPLE <input type="checkbox"/> EQUIPMENT <input type="checkbox"/> MATERIALS <input type="checkbox"/> PROCESS <input type="checkbox"/> ENVIRONMENT		
	DETAILS: _____		
	INVESTIGATION – INCLUDE ALL CONDITIONS THAT CONTRIBUTED TO THE INCIDENT		
Who? _____			
What? _____			
Where? _____			
How? _____			
Why? _____			
ACTIONS TO PREVENT INCIDENT RECURRENCE			
MARK WITH (✓) THOSE ACTIONS TAKEN TO PREVENT RECURRENCE. MARK WITH (P) OTHER CORRECTIVE ACTIONS DECIDED UPON OR PLANNED BUT NOT YET CARRIED OUT. MORE THAN ONE ITEM MAY APPLY.			
<input type="checkbox"/> IMPROVED PERSONAL PROTECTIVE EQUIPMENT <input type="checkbox"/> ACTIONS TO IMPROVE DESIGN/PROCEDURE <input type="checkbox"/> REINSTRUCTION OF PERSON INVOLVED <input type="checkbox"/> CHECK WITH MANUFACTURER <input type="checkbox"/> REASSIGNMENT OF PERSON <input type="checkbox"/> INFORM ALL DEPARTMENT SUPERVISION <input type="checkbox"/> ORDER JOB SAFETY ANALYSIS DONE <input type="checkbox"/> DISCIPLINE OF PERSONS INVOLVED <input type="checkbox"/> ACTION TO IMPROVE INSPECTION <input type="checkbox"/> INSTALLATION OF GUARD OR SAFETY DEVICE <input type="checkbox"/> EQUIPMENT REPAIR OR REPLACEMENT <input type="checkbox"/> OTHER (EXPLAIN) _____ <input type="checkbox"/> CORRECTION OF CONGESTED AREA			
DETAILS OF ACTIONS TAKEN TO PREVENT RECURRENCE			
1. _____			
2. _____			
3. _____			
4. _____			
SIGNATURE OF MANAGER/SUPERVISOR WHO COMPLETED INVESTIGATION		EMPLOYEE SIGNATURE:	
Has employee had similar disability <input type="checkbox"/> Yes <input type="checkbox"/> No Physician's Name: _____ Did employee visit Occupational Health & Safety Centre <input type="checkbox"/> Yes <input type="checkbox"/> No Chiropractor/Physio: _____ Did employee visit Emergency Department at SAH <input type="checkbox"/> Yes <input type="checkbox"/> No Same Day Appointment Clinic at GHC <input type="checkbox"/> Yes <input type="checkbox"/> No Employee will: <input type="checkbox"/> Resume Regular Duty <input type="checkbox"/> Modified Duty <input type="checkbox"/> Remain off Work Signature: _____ Date: _____			
HUMAN RESOURCES			