INCIDENT / ACCIDENT REPORT FORM

for Employees

(and Unpaid Postsecondary Placement Students)

INSTRUCTIONS FOR INCIDENT / ACCIDENT REPORTING:

1. Principal/Supervisor to complete form with Employee, sign and date below (Employee to keep copy for his/her records)
2. For unpaid University/College Placement Student, Principal/Supervisor to complete form with Student replacing EIN with SIN in section A1
3. Fax form to Health , Safety and Security (HSS) within 24 hours of the incident/accident → **FAX: 519-570-5561**

INSTRUCTIONS FOR HEALTH AND SAFETY CONCERNS ONLY:

EMPLOYEE: 1. Complete sections **A1** and **A4**

PRINCIPAL/ SUPERVISOR: 1. Review concern **(A4)**, investigate, and complete section **B3** 2. Sign form and fax (519-570-5561) to HSS when complete (refer to AP 3140 for process and timeline)

SECTION A *To be completed by the Employee and/or Principal/Supervisor*

A1 EMPLOYEE INFORMATION

Name: ______________________ Today's Date: ______________ Employee's E.I.N.: ________

Job Title: ______________________ Department: ______________________

Work Location: ______________________ Principal/Supervisor: ______________________

A2 HISTORY OF THE INCIDENT / ACCIDENT

Date of Incident/Accident: ____________ Time of Incident/Accident: ________ AM PM Time Reported: ________ AM PM

Date Reported: ____________ Incident/Accident reported to?: ______________________

If report is delayed, please explain why: ______________________

Exact location of incident/accident (i.e.,hallway, gym): ______________________

Name(s) of eye-witness(es): ______________________

A3 SPECIFICS OF THE INCIDENT / ACCIDENT

1. Type of incident/accident: **(check all that apply)**

No Injury

First Aid

Health Care [i.e., Doctor, Hospital] [Complete 2.]

Lost Time [Complete 3.]

Critical Injury/Fatality [Notify Urgent Response IMMEDIATELY at 519-570-0003, ext. 4123 and HSS ext. 4504 - refer to AP 3140]

2. Did you visit a medical professional related to the incident/accident?: **YES** → Date of Medical Treatment: ____________

If you visit a medical professional or miss time at work due to your injury <u>after form has been submitted</u>, contact the Wellness Office IMMEDIATELY at 519-570-0003, ext. 4567.

Name of Medical Institution: ____________

Name of Medical Professional: ____________

3. For Lost Time: Last Date Work: ____________ Last Hour Worked: ________ Regular Hours of Work: ________

4. Has the employee had a similar or related injury or condition? **YES** **NO** Details: ____________

5. The incident/accident was:

- Sudden Specific Event
- Gradual Occurring Over Time
- Occupational Disease/Illness

6. GdYW[Z]Wg cZ]bW]XYbh#UWW]XYbh (check all that apply):

- Fall (from a height)
- Slip, Trip, Fall (same level)
- Struck Against/Contact With
- Struck By or Contact By
- Caught In, On, or Between
- Repetition
- Over Exertion/Strain
- Motor Vehicle Accident
- Environmental (i.e.,Temp, Air)
- Exposure
- Fire/Explosion
- Harmful Substance
- Aggression (Adult)
- Aggression (Student)
- ▸ Safety Plan: **YES** **NO**
- Other: ________

A4 DESCRIPTION OF INCIDENT / ACCIDENT or HEALTH AND SAFETY CONCERN

Describe the sequence of events, what happened, what you were doing, leading up to and including the incident/accident; or describe the specifics of your concern.

____

____

____

____

____

Incident verified by the Principal/ Supervisor? **YES**

________ Initials of Principal/Supervisor

A5 INJURY DESCRIPTION **Describe the Injury:** ______________________ **(L = Left Side or R = Right Side)**

L	R		L	R		L	R		L	R		L	R		L	R	
		Head			Shoulder			Middle Back			Elbow			Hip			Lower Leg
		Face			Chest			Lower Back			Wrist			Thigh			Ankle
		Eyes			Abdomen			Upper Arm			Hand			Upper Leg			Foot
		Neck			Upper Back			Lower Arm			Finger(s)			Knee			Internal Injury

Other (please specify): ______________________

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SECTION B *To be completed by the Principal /Supervisor (with Employee, if possible)*

B1 ROOT CAUSE

The conditions that contributed to the incident/accident (check all that apply):

- Use of Unsafe/Improper Equipment
- Improper Position or Posture
- Willful Misconduct
- Failure to Use Personal Protective Equipment (PPE)
- Inadequate Illumination
- Hazardous Environmental Condition/Weather
- Improperly Labelled/Identified
- Improper Ventilation
- Inadequate Clearance/Workspace
- Inadequate Instruction/Training/Experience
- Guarding Inadequate/Removed/Tampered With
- Inadequate Housekeeping/Maintenance
- Unrequired Activities/Beyond Physical Capability
- Failure to Follow Established Work Procedure/ Practice
- Failure to Lock Out
- Chemical Handling
- Medical Condition
- Inattention/Human Error
- Failure to Obtain Assistance
- Following Safety Plan? YES NO
- Other (Specify): ____________________

Behaviour: Student Staff Other: ____________________

Aggression: Threat of Physical Violence Attempt of Physical Violence Exercised Physical Violence

B2 SPECIFICS OF ROOT CAUSE

Provide details of equipment, material, and/or environmental conditions (work area, temperature, noise, chemical exposures, etc.) that contributed to the root cause. If cause involves other people, what were the triggers?

____

B3 CORRECTIVE AND/OR PREVENTATIVE ACTIONS

Describe actions taken to correct or prevent recurrence of the incident/accident or health and safety concern.

	Action	Date Completed (dd/mm/yy)	Date Planned (dd/mm/yy)	Communicated to Employee?
1				Yes No
2				Yes No

NOTE: For health and safety concerns, Principals/Supervisors must respond within 7 working days (holidays excluded) upon receipt of this form from an Employee.

SIGNATURES

I verify that the above information is accurate to the best of my recollection.

EMPLOYEE SIGNATURE: ____________________

DATE: ____________________

I have investigated the incident/accident and have taken actions to prevent a recurrence.

PRINCIPAL/SUPERVISOR SIGNATURE: ____________________

DATE: ____________________

NOTICE: The information collected in Section A is pursuant to the requirements of the Workplace Safety & Insurance Act and Occupational Health & Safety Act. It will be used for a WSIB Form 7 and/or investigation by the HSS department.

This section to be completed by authorized WRDSB staff.

Yes	No	Follow-up Actions by Health, Safety and Security	Yes	No	
		Entered into Parklane?			Principal/Supervisor contacted Date:
		Copy sent to HR Assistant - Wellness (WSIB)?			Comments:
		Copy sent to Health, Safety & Security Officer			
		Copy sent to Special Education Department			