Accident/Incident Reporting Form & Investigation Report

FAX COMPLETED FORM *(Within 24 hours)* TO: 519-661-2079 (82079)

MAIL TO: Room 4159, Support Services Building, Rehabilitation Services

SECTION #1 – Accident/Incident Reporting Form

PART A

Name of Employee: _____ **Employee Number:** _____

Contact Telephone Number of Employee: (Home)_____ **(Cell)**_____

Employee Group*(if applicable)*: □ UWOSA □ PMA □ CUPE 2361 □ CUPE 2692 □ IUOE □ PSAC 610 □ SAGE □ UWOFA □ UWOPA

Status: □RF □RP/TM □CW □Undergrad Student □Grad Student □Other/Visitor

Type: □Report Only □Accident □Incident □No Injury/Hazard □ First Aid □ Lost Time □ Non-Lost Time

(If Report Only, please complete Section #1 - Parts A,B,and F – Supervisor will retain report and give copy to employee)

PART B

Date & Time of Accident/Incident: _____ **Time:** _____ **a.m/p.m**
Day/Month/Year

Date & Time Accident/Incident Reported: _____ **Time:** _____ **a.m/p.m.**
Day/Month/Year

Description of Accident/Incident:(*What happened to cause the accident/incident? What was the person doing? Was there any equipment, people or materials involved- identify the size, weight and type)*

_____

_____

_____

_____

_____

_____

Part of body injured (specify left or right side):

_____

Location/Area of Accident/Incident or Hazardous Situation (Building and Rm #):

_____

Name & Contact Information of Witness(es): _____

(If there are witnesses, please include a statement from each witness)

PART C

Treatment of Injury:

1. **Did the Employee/Student receive First Aid and by whom?** **YES □ NO □**
   If YES, give treatment details: _____
2. **Did the Employee/Student visit Workplace/Student Health?** **YES □ NO □**
3. **Did the Employee visit Hospital and/or Physician?** **YES □ NO □**
   If YES, what hospital/physician, date & time, address, phone number & give transportation details(e.g. ambulance) :

_____

To your knowledge, has the person had a similar disability? If YES, please explain below **YES □ NO □**

_____

SECTION #2 – Investigation Report

PART D

Immediately investigate if any of the following occur: Fatalities, Critical Injuries, Lost Time, Occupational Illness, Property Damage, Fire or Environmental Release

Is the employee off work due to this accident/incident ? □ **Yes** □ **No**

Date & Hour Last Worked: _____ a.m./p.m.
Day/Month/Year/Time

Employee Return to Work Date: _____ a.m./p.m.
Day/Month/Year/Time

Normal Working Hours & Days:

	Sun	Mon	Tue	Wed	Thu	Fri	Sat
Time							
Hours							

PART E

Contributing Factors (Check √ applicable factors):

□ **Hazardous method/procedure used**
□ **Improper position/posture (ergonomics)**
□ **Inadequate personal protective equipment**
□ **Incorrect/defective tools**
□ **Unsafe design or construction**
□ **Poor weather conditions**
□ **Hazardous housekeeping or arrangement**
□ **Inexperience of person in the task**
□ **Training/job instruction inadequate**
□ **Inadequate guarding of material & equipment**
□ **Inadequate lighting/ventilation**
□ **Other: _____**

_____

Detail Factors: _____

Actions and Follow up to prevent Recurrence:

□ **Contact Occupational Health & Safety for assistance**
□ **Contact Physical Plant Department for assistance**
□ **Actions to improve design/procedures**
□ **Correct congested area**
□ **Repair or replace tool/equipment**
□ **Improve personal protective equipment**
□ **Install guard or safety device**
□ **Reinstruct person involved & provide support/coaching**
□ **Request Ergonomic Assessment**
□ **Update training**
□ **Refer to Rehabilitation Services**

**** Supervisor to provide a detailed Action Plan below****

ACTION PLAN

Action Plan(include what, why & how recommendations are made)	**Party Responsible**	**Completed Date**	**Follow Up**

PART F

INVESTIGATED BY:

Name of Supervisor: _____ (print name) Telephone Number: _____

Supervisor Signature: _____ Date: _____

REVIEWED BY:

Management (Department Chair or Unit Head) Signature:

_____ Date: _____

Employee Signature: _____ Date: _____

JOHSC Rep Signature: _____ Date: _____
(if applicable)

OHS Signature: _____ Date: _____
(if applicable)

****FAX COMPLETED FORM TO 519-661-2079 OR EXT 82079 (ON CAMPUS)****

PART G

Distribution List: **Initial - Sent Off:**

Distribute copies to:
(Supervisor to do)

1) Workplace/Student Health Services (UCC 25) _____
2) Budget Unit Head/Supervisor or Chair _____
3) Employee/Student/Visitor _____
4) Originator _____
5) Applicable Employee's Union/Staff Group – JOHSC Rep
UWOSA-UCC 255 _____
PMA-UCC 351 _____
CUPE 2361 FM-SSB 1320 _____
CUPE 2692 HS -Perth Hall 152 _____
UWOPA-LwH 1257 _____
IUOE _____
PSAC 610-UCC 270 _____
SAGE-STvH 3107P _____
UWOFA-ELBORN _____

WITNESS STATEMENT ***(Include for each witness when submitting AIIR)***

Name of Witness: _____

Contact Information: _____

Phone/Ext: _____

Date and Time of Accident/Incident: _____

Injured Worker's Name: _____

Location of Accident/Incident: _____

Your Account of the Accident/Incident:

_____

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_____

Name of Witness: _____ **Date:** _____

Signature of Witness: _____

ADDITIONAL INFORMATION

Name: _____ **Date:** _____

Signature: _____