

Incident Report



All first aid, health care and lost time incidents that are work-related are required to be reported by law.

If this is a Critical Injury, call ERC at 613-533-6111 or 911 immediately.

Arrange first aid treatment or health care if needed.

Lost time begins once employee is absent or unable to work on any day after the incident due to work related injury.

A. Injured Person Information			
Role at time of Incident/Injury: <input type="checkbox"/> Employee <input type="checkbox"/> Student-Staff <input type="checkbox"/> Unpaid Student <input type="checkbox"/> Visitor <input type="checkbox"/> Volunteer			
First Name:	Last Name:	Staff or Student ID No.:	
Mailing Address:		Preferred Language: <input type="checkbox"/> English <input type="checkbox"/> French <input type="checkbox"/> Other _____	
City/Town:	Province	Postal Code:	Date of Birth (DD/MM/YY):
Home/Cell Telephone:		Start date of current job (DD/MM/YY):	
Work Telephone:			
Department:		Job title at time of injury:	
Were you engaged in an employment activity during the incident? <input type="checkbox"/> Yes <input type="checkbox"/> No			

B. Incident/Injury Details			
Type of Incident: <input type="checkbox"/> No Injury /Near Miss /Hazard <input type="checkbox"/> Injury with No Treatment <input type="checkbox"/> First Aid (bandage, ice pack etc.) <input type="checkbox"/> Health Care (treatment, tests by Doctor, Hospital, Health Facility) <input type="checkbox"/> Lost Time after date of Incident			
Date of Incident (DD/MM/YY):	Time of Incident: _____ <input type="checkbox"/> AM <input type="checkbox"/> PM	Date Reported to Supervisor (DD/MM/YY):	Time reported to Supervisor: _____ <input type="checkbox"/> AM <input type="checkbox"/> PM
Name of supervisor that incident/injury was reported to (Name & Position):		Telephone: Ext:	
Specific location of incident/illness (name of building/ floor/ room/ street/ pathway location/parking lot):			
Are you aware of any witnesses or persons involved in this accident/illness? <input type="checkbox"/> Yes <input type="checkbox"/> No			
If yes, provide name(s), position(s), and work phone number(s):			

(1) Describe what the worker was doing at the time, what occurred. (2) Specify resulting injury or type of hazardous exposure, (3) conditions that may have contributed. E.g., work area, equipment, procedure, animal, environment (noise, chemical, gas etc).

For a condition that occurred gradually over time, include a description of the physical activity required to do the work. Attach additional page if necessary.

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Type of Accident/Illness: (Please check all that apply)		
<input type="checkbox"/> Struck/Caught	<input type="checkbox"/> Fall from height	<input type="checkbox"/> Motor Vehicle Incident
<input type="checkbox"/> Overexertion	<input type="checkbox"/> Harmful Substances/Environmental (chemical, etc.)	<input type="checkbox"/> Assault
<input type="checkbox"/> Repetition	<input type="checkbox"/> Animal	<input type="checkbox"/> Fire/Explosion
<input type="checkbox"/> Slip/Trip	<input type="checkbox"/> Needle stick - specify exposure type	<input type="checkbox"/> Other

Area of Injury (Body Part): (Please check all that apply)													
<input type="checkbox"/> Head	<i>Left</i>	<input type="checkbox"/> Eye	<i>Right</i>	<input type="checkbox"/>	<i>Left</i>	<input type="checkbox"/> Shoulder	<i>Right</i>	<input type="checkbox"/>	<i>Left</i>	<input type="checkbox"/> Hip	<i>Right</i>	<input type="checkbox"/>	<input type="checkbox"/> Upper Back
<input type="checkbox"/> Face		<input type="checkbox"/> Ear		<input type="checkbox"/>	<input type="checkbox"/> Arm		<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/> Thigh		<input type="checkbox"/>	<input type="checkbox"/> Lower Back
<input type="checkbox"/> Teeth				<input type="checkbox"/>	<input type="checkbox"/> Elbow		<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/> Knee		<input type="checkbox"/>	<input type="checkbox"/> Abdomen
<input type="checkbox"/> Neck				<input type="checkbox"/>	<input type="checkbox"/> Forearm		<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/> Lower Leg		<input type="checkbox"/>	<input type="checkbox"/> Pelvis
<input type="checkbox"/> Chest				<input type="checkbox"/>	<input type="checkbox"/> Wrist		<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/> Ankle		<input type="checkbox"/>	<input type="checkbox"/> Other
				<input type="checkbox"/>	<input type="checkbox"/> Hand		<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/> Foot		<input type="checkbox"/>
				<input type="checkbox"/>	<input type="checkbox"/> Finger(s)		<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/> Toe(s)		<input type="checkbox"/>

C. Investigation / Corrective Action – THIS SECTION TO BE COMPLETED BY SUPERVISOR

Causes contributing to incident: (Please check all that apply)		
<input type="checkbox"/> Unsafe equipment or tools	<input type="checkbox"/> Failure to use personal protective equipment / used incorrect PPE	<input type="checkbox"/> Hazardous workspace/ facility
<input type="checkbox"/> Unsafe loading, lifting, placing	<input type="checkbox"/> Unsafe posture, position, ergonomics	<input type="checkbox"/> Hazardous personal attire
<input type="checkbox"/> Hazardous method/procedure	<input type="checkbox"/> Failure to follow established procedures	<input type="checkbox"/> Hazardous condition, weather
<input type="checkbox"/> No identified procedure or lack of SOP	<input type="checkbox"/> Lack of experience, skill of person performing task or using equipment	<input type="checkbox"/> Repetitive action
<input type="checkbox"/> Inadequate training	<input type="checkbox"/> Hazardous housekeeping	<input type="checkbox"/> Sharps-related
<input type="checkbox"/> Fire, explosion, atmospheric hazard	<input type="checkbox"/> Personal medical condition	<input type="checkbox"/> Other – please explain:

Have you determined the root cause of incident? Yes No

Has this happened before? Yes No If so, Why?

If full investigation has not been completed, submit report form, then forward investigative results once determined.

What Corrective action or changes can be made to avoid recurrence: (Please check all that apply)

<input type="checkbox"/> Contact Facilities (PPS)	<input type="checkbox"/> Repair, replace tool or equipment	<input type="checkbox"/> Redesign task
<input type="checkbox"/> Arrange ergonomic assessment	<input type="checkbox"/> Provide hazard-specific training/ highlight content in training	<input type="checkbox"/> Other –explain:
<input type="checkbox"/> Remove hazard	<input type="checkbox"/> Routinely inspect areas for hazards
<input type="checkbox"/> Clarify SOP/Procedures	

Plan - What action or changes have been made/will be made to ensure it does not re-occur in your workplace?

Action Taken:	Person Responsible	Target Date of completion

D. Health Care (Complete this section only if there was health care/medical attention)		
When did the person receive health care for this injury (DD/MM/YY)?	When did the supervisor learn that the person received health care (DD/MM/YY)?	
Where was the person treated for this injury? (Please check all that apply)		
<input type="checkbox"/> Ambulance <input type="checkbox"/> Emergency department <input type="checkbox"/> Admitted to hospital <input type="checkbox"/> Health professional office <input type="checkbox"/> Clinic <input type="checkbox"/> Walsh & Assoc. Occupational Health <input type="checkbox"/> Other		
Name, address and phone number of health professional(s) or facility who treated the person:		
Are you aware of any prior or related problems, injury or conditions? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Have you received work limitations/restrictions for this injury? <input type="checkbox"/> Yes <input type="checkbox"/> No	Has modified work been offered to this worker? <input type="checkbox"/> Yes <input type="checkbox"/> No	Has modified work been accepted by this worker? <input type="checkbox"/> Yes <input type="checkbox"/> No

E. Lost Time						
The next day/shift after the accident, did the person:						
<input type="checkbox"/> Return to regular work <input type="checkbox"/> Return to modified work <input type="checkbox"/> Lose work time and/or earnings						
This lost time information was confirmed by (Name, Position, Telephone):						
Complete following questions only if there was lost time from work after day of incident						
Date and time last worked (DD/MM/YY): _____ <input type="checkbox"/> AM <input type="checkbox"/> PM	Normal working hours on day of injury: Start _____ <input type="checkbox"/> AM <input type="checkbox"/> PM Finish _____ <input type="checkbox"/> AM <input type="checkbox"/> PM	Expected date of return (DD/MM/YY):				
Regular Hours/schedule per day. (If employee works irregular schedule, please let us know)						
Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday

Additional Comments or Concerns:

Queen's Supervisor / Department representative – Print Name and Signature:	Date:
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The personal information on this form is collected under the authority of the Royal Charter of 1841, as amended. If you have any questions or concerns about the information collected or how it will be used, please contact the Department of Environmental Health and Safety by telephone at 613-533-2999.