



HEALTH & SAFETY INCIDENT REPORT

(including workplace accidents, injuries and near misses)

To be completed by Employee/Student

Please complete as fully as possible.

Last Name:	First Name:	Date of Report:
Street Address:	City/Prov:	Postal Code:
Home Telephone:	Work Telephone:	Date of Birth (YYYY/MM/DD):
Job Title (or student/visitor):	Location where injury/incident took place (Campus/Building/Room No):	
Date & Time of Injury/Incident:	First reported to (check one and include name):	
	<input type="checkbox"/> Supervisor	
Date & Time Reported:	<input type="checkbox"/> First Aid Attendant	
	<input type="checkbox"/> Instructor	

To be completed by Supervisor and/or First Aid Attendant	Name:
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Names and addresses of witnesses:

Accident/Incident category:	<input type="checkbox"/> No injury	<input type="checkbox"/> Medical Treatment	<input type="checkbox"/> Property Damage	<input type="checkbox"/> Fire
	<input type="checkbox"/> Other (please specify)			
Severity of injury or illness:	<input type="checkbox"/> First Aid Only	<input type="checkbox"/> Medical Treatment	<input type="checkbox"/> Disabling	<input type="checkbox"/> Fatal

Nature of injury or illness:

Description of incident/accident (or employee's account of illness):

Describe the results of incident or illness (property damage, type of injury, nature of illness), first aid required and disposition (return to work, to medical care, etc):

Any time loss from work?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Any time loss on day of injury?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Any time loss beyond the day of injury?	<input type="checkbox"/> Yes # of days ____ <input type="checkbox"/> No
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Note: If there is any time loss or if you see a doctor at a later date, you must **notify your supervisor/instructor and the Health & Safety Department (local 4573/5682) immediately** to ensure that the appropriate forms are filed with WorkSafeBC (Employees, apprenticeship students, or students on practicum).

See next page...

To be completed by Supervisor/Instructor

Name:

Were person's actions at time of injury/incident for the purpose of OC business?

Yes

No

If NO, explain:

Were person's actions at time of injury/incident part of his/her regular work?

Yes

No

If NO, explain:

Was any person not employed by OC responsible for this injury/incident?

Yes

No

If YES, provide name and address of such person:

Are you aware of any previous pain or disability in the area of the present injury?

Yes

No

If YES, explain:

Are you aware of any disability of the worker prior to injury?

Yes

No

If YES, explain:

What are basic causes and contributing factors? Explain in full any unsafe acts, conditions or personal factors:

Supervisor/Instructor Signature:

Date:

To be completed by Health & Safety Manager

Name:

Corrective Actions:

- 1) Action required:
- 2) By whom:
- 3) By when:

Name(s) and occupation(s) of person(s) who investigated accident:

Completed form to be forwarded IMMEDIATELY to the Health & Safety Manager. In the event of a serious incident, phone the Health & Safety Manager immediately (local 4573/5682), so that a full investigation of the incident may commence.