University of King's College
Non-Contract Employees

EMPLOYEE ACCIDENT/INCIDENT REPORT

To be completed within 24 hours of the accident/incident and sent to the Chair of the Occupational Health and Safety Committee.

EMPLOYEE IDENTIFICATION

Name: _____ Phone No.: _____

Address: _____

City: _____ Province.: _____

Postal Code: _____ Birth Date: _____

Job Title: _____ Length of Employment: _____

ACCIDENT/INCIDENT INFORMATION (to be completed by Employee)

Date of Incident: _____ Time of Incident: _____

Location of Incident:

Inside (Building & Room #) _____Outdoors (Description) _____

Was Supervisor Notified? Yes _____ No _____ Date & Time Notified: _____

Name of Immediate Supervisor: _____

Was injured person performing regular job duties at time of incident? Yes ___ No ___

Did incident result in injury? Yes ____ No _____

Did incident result in loss of property? Yes ____ No _____

Complete description of incident:

_____

_____

_____

_____

_____

_____

Circumstances that lead to incident, i.e., unfamiliar with task, lack of concentration, improper instruction, etc.

_____

What measures could have been taken to prevent this incident?

_____

If there was damage to property, describe the extent of loss to the best of your knowledge: _____

_____

_____

Witnesses? Yes ____ No _____

Contact information of witness:

Name: _____ Phone No.: _____

Address: _____

City: _____ Prov.: _____ Postal Code: _____

Bodily injury - Body part injured:

(Circle all that apply)

Left Right

Hand	Elbow	Ankle
Thumb	Shoulder	Foot
Finger(s)	Thigh	Toe(s)
Wrist	Knee	Eye
Arm	Calf	Ear
Face	Teeth	Other
Head	Abdomen	Groin
Back (lower)	Back (mid)	Back (upper)
Nose	Throat	Lungs

Nature of Injury:

laceration	sprain	other puncture strain
insect/animal bite	fracture/dislocation	
burn	inhalation	
abrasion	scrape	foreign matter
contusion	bruise	skin irritation
exposure to body fluids		

Was this incident the result of a slip, trip, or fall? Yes _____ No _____

Was this incident the result of lifting? Yes _____ No _____

Approximate weight of object?_____ How high lifted?_____

Was kind of work performed regularly? Yes _____ No _____

Were you subject to unusual strain or circumstances? Yes _____ No _____

If yes, explain: _____

Did injury appear immediately? Yes _____ No _____

If yes, Explain: _____

What was the length of time between the injury and your symptoms?

Were you treated by a doctor? Yes _____ No _____

If yes, name of doctor _____ Date treated _____

Did you go to the hospital? Yes _____ No _____

If yes, name of hospital _____ Date treated _____

Was first aid given? Yes _____ No _____

By whom (self - using first aid kit, other):

Have you ever filed a Workers Compensation Claim? Yes _____ No _____

If yes, when and where: _____

Nature of previous claim(s): _____

_____

Is this injury an aggravation of an old injury? Yes _____ No _____

I, the injured employee, herein certify that the information set forth above is true and correct to the best of my knowledge. By signing this form, I expressly waive all provisions of law which forbid any person or persons who heretofore did or who hereafter may medically attend, treat, or examine me or who may have information of any kind which may be used to render a decision in my claim for injury/disease of (Date) from disclosing such knowledge to my employer and/or any other agency contracted by employer to investigate this health claim. A copy of this form will serve as the original.

Employee Signature: _____ Date: _____

Print Name: _____

Supervisor's Signature: _____ Date: _____

Print Name: _____