EMPLOYEE ACCIDENT/INCIDENT REPORT (Non-contract employees)

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

SECTION 1

EMPLOYEE IDENTIFICATION

Name: ______________________________ Phone No.: __________________

Address: ____

City: __________________________ Province.: ________________________

Postal Code: ____________________ Birth Date: _______________________

Job Title: ________________________Length of Employment: ______________

SECTION 2

ACCIDENT/INCIDENT INFORMATION (to be completed by employee)

Date of Incident: __________________ Time of Incident: ___________________

Location of Incident:

Indoors (Building & Room #) __________Outdoors (Description) ___________________

Complete description of incident:

____

____

____

____

Was Supervisor Notified? Yes ___ No___ Date/Time Notified: ____________________

Name of Immediate Supervisor: __________________________________

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

Did incident result in loss of property? Yes ____ No_____

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 _____

Witness Name: ___________________________ Phone No.: ____________________

Address: ____

City: ______________________________ Prov.: ______ Postal Code: ___________

Did incident result in physical injury? Yes ____ No *____

***If answer is NO please proceed to Section 3**

Physical injury - Body part injured: (circle all that apply)

Hand	Back (upper)	Head
Thumb	Back (mid)	Face
Finger(s)	Back (lower)	Eye(s)
Wrist	Leg (upper)	Ear(s)
Arm (upper)	Knee	Nose
Elbow	Leg (lower)	Mouth
Arm (lower)	Calf	Teeth
Shoulder	Ankle	Throat
Abdomen	Foot	Other_________________
Chest	Toe(s)	Left (if applicable)
Lungs	Groin	Right (if applicable)

Nature of physical injury: (circle all that apply)

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

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, please 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 ______

SECTION 3

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, 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: ___________________________________

Signature upon receipt of completed form by

Chair, Occupational Health & Safety

Signature____ Date__________________

Print Name____