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. Person Involved or Injured Information

Role at time of Incident/Injury: ☐ Employee ☐ Student-Staff ☐ Unpaid Student ☐ Visitor ☐ Volunteer

First Name:	Last Name:		Staff or Student ID No.:
Mailing Address:			Preferred Language: ☐ English ☐ French ☐ 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? ☐ Yes ☐ No

B. Incident/Injury Details

Type of Incident:

☐ No Injury/Near Miss/Hazard ☐ Injury with No Treatment ☐ First Aid (bandage, ice pack etc.)
☐ Health Care (treatment, tests by Doctor, Hospital, Health Facility) ☐ Lost Time after Date of Incident

Date of Incident (DD/MM/YY):	Time of Incident: _____ ☐ AM ☐ PM	Date Reported to Supervisor (DD/MM/YY):	Time reported to Supervisor: ___ ___ ☐ AM ☐ PM

Name of supervisor that incident/injury was reported to (Name & Position): Telephone: Ext:

Specific location of incident/illness - building, floor, room. Identify type of space: lab, office, street/ pathway /parking lot):

Are you aware of any witnesses or persons involved in this accident/illness? ☐ Yes ☐ No
If yes, provide name(s), position(s), and work phone number(s):
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(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**

☐ Struck/Caught	☐ Fall from height	☐ Motor Vehicle Incident
☐ Overexertion	☐ Harmful Substances/Environmental (chemical, etc.)	☐ Assault
☐ Repetition	☐ Animal	☐ Fire/Explosion
☐ Slip/Trip	☐ Needle stick - specify exposure type	☐ Other .....

Area of Injury (Body Part): **Please check all that apply**

	Left	*Right*	*Left*	*Right*	*Left*	*Right*	
☐ Head	☐ Eye	☐	☐ Shoulder	☐	☐ Hip	☐	☐ Upper Back
☐ Face	☐ Ear	☐	☐ Arm	☐	☐ Thigh	☐	☐ Lower Back
☐ Teeth			☐ Elbow	☐	☐ Knee	☐	☐ Abdomen
☐ Neck			☐ Forearm	☐	☐ Lower Leg	☐	☐ Pelvis
☐ Chest			☐ Wrist	☐	☐ Ankle	☐	☐ Other
			☐ Hand	☐	☐ Foot	☐	.....
			☐ Finger(s)	☐	☐ Toe(s)	☐	

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

Causes contributing to incident: **There may be more than one, check all that apply**

☐ Unsafe equipment or tools	☐ Failure to use personal protective equipment / used incorrect PPE	☐ Hazardous workspace/ facility
☐ Unsafe loading, lifting, placing	☐ Unsafe posture, position, ergonomics	☐ Hazardous personal attire
☐ Hazardous method/procedure	☐ Failure to follow established procedures	☐ Hazardous condition, weather
☐ No identified procedure or lack of SOP	☐ Lack of experience, skill of person performing task or using equipment	☐ Repetitive action
☐ Inadequate training	☐ Hazardous housekeeping	☐ Sharps-related
☐ Fire, explosion, atmospheric hazard	☐ Personal medical condition	☐ 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)**

☐ Contact Facilities (PPS)	☐ Repair, replace tool or equipment	☐ Redesign task
☐ Arrange ergonomic assessment	☐ Provide hazard-specific training/ highlight content in training	☐ Other – please explain: ....
☐ Remove hazard	☐ Routinely inspect areas for hazards	
☐ 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 **Has there been or will there be health care/medical attention?** Yes No	
When did/will 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)

☐ Ambulance ☐ Emergency department ☐ Admitted to hospital ☐ Health professional office ☐ Clinic

☐ Walsh & Assoc. Occupational Health ☐ Other .....

Name, address and phone number of health professional(s) or facility who treated the person:

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Are you aware of any prior or related problems, injury or conditions? ☐ Yes ☐ No

Have you received work limitations/ restrictions for this injury? ☐ Yes ☐ No	Has modified work been offered to this worker? ☐ Yes ☐ No	Has modified work been accepted by this worker? ☐ Yes ☐ No

E. Lost Time		
The **next day/shift after** the accident, did the person (wait until next day for this question): ☐ Return to regular work ☐ Return to modified work ☐ 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): _____ ☐AM ☐PM	Normal working hours on day of injury: Start _____ ☐AM ☐PM Finish _____ ☐AM ☐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:**

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.