

ACCIDENT INCIDENT / CRITICAL INJURY REPORTING FORM (revised 10/15/2020)
TO BE COMPLETED WITHIN 24 HOURS OF ACCIDENT/INCIDENT
SEND COPY TO HR AND ORIGINAL TO I&S ADMINISTRATIVE MANAGER

Section A: INFORMATION Employee: Student: Visitor:

Name of injured person: _____
 Work address/Residence: _____
 Street Apt. City/Town Postal Code
 Phone: _____ Date of Hire: _____ Student ID: _____
 dd / mm / yyyy
 Department: _____ Job Title: _____ Length of time in position: _____

Accident Information:

Date of Accident: _____ Time: _____ AM PM
 Date Reported: _____ Time: _____ AM PM
 Person Reported to: _____
 (Name) (Position)
 Location of Accident: _____

Medical Information: Is this a work-related Injury? Yes No

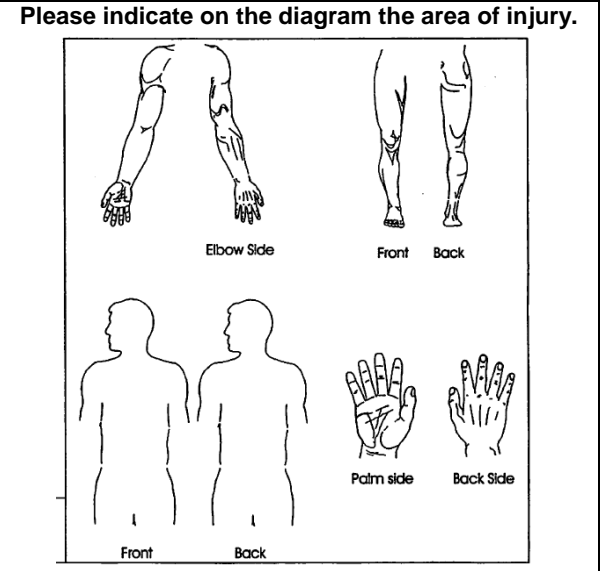
Type of Injury/Incident: First Aid Medical Aid Lost Time Property/Near Miss

Where was medical attention sought: _____
 Doctor Name or Hospital
 Address City/Town Postal Code Phone #

Section B: INJURY REPORT

- Injury Source (check all that apply):**
- Equipment
 - Machinery
 - Tools
 - Materials
 - Chemicals
 - Electrical Source
 - Temperature Extreme
 - Violence
 - Fire/Explosion
 - Other: _____

- Contact Type (check all that apply):**
- Struck Against
 - Struck By
 - Caught On
 - Caught In
 - Caught Between
 - Slip/Trip/ Fall
 - Overexertion
 - Repetition
 - Motor Vehicle
 - Harmful Substance/Environ



Other _____

Area of Injury (check all that apply):

- Head Teeth Upper Back Face Eye(s) Ear(s) Neck
 Chest Abdomen Lower Back Pelvis Other _____

- | | | | | | | | | |
|------------------|-------------------------------|--------------------------------|----------------|-------------------------------|--------------------------------|---------------|-------------------------------|--------------------------------|
| Shoulder | <input type="checkbox"/> Left | <input type="checkbox"/> Right | Wrist | <input type="checkbox"/> Left | <input type="checkbox"/> Right | Hip | <input type="checkbox"/> Left | <input type="checkbox"/> Right |
| Arm | <input type="checkbox"/> Left | <input type="checkbox"/> Right | Hand | <input type="checkbox"/> Left | <input type="checkbox"/> Right | Thigh | <input type="checkbox"/> Left | <input type="checkbox"/> Right |
| Elbow | <input type="checkbox"/> Left | <input type="checkbox"/> Right | Fingers | <input type="checkbox"/> Left | <input type="checkbox"/> Right | Knee | <input type="checkbox"/> Left | <input type="checkbox"/> Right |
| Forearm | <input type="checkbox"/> Left | <input type="checkbox"/> Right | Ankle | <input type="checkbox"/> Left | <input type="checkbox"/> Right | Toe(s) | <input type="checkbox"/> Left | <input type="checkbox"/> Right |
| Lower Leg | <input type="checkbox"/> Left | <input type="checkbox"/> Right | Foot | <input type="checkbox"/> Left | <input type="checkbox"/> Right | | | |

Injured Employee Statement: (employees are not required to provide medical or confidential information)

Describe what happened to cause the accident/incident and what you were doing at the time. Include what the injury is and any details of equipment, materials, environmental conditions (temperature, work area, etc.) that may have contributed to the injury/incident. Please provide as much detail as possible, including weights, distances, type of movement, equipment, tools etc.

Names and work locations of all witnesses:

SECTION C: WITNESS STATEMENT

Occurrence Information:

Location of Occurrence: _____

Date of Occurrence: _____

Time of Occurrence: _____ AM PM

Date Reported: _____

Time Reported: _____ AM PM

Statement Given By: Witness

Other _____

Name: _____

Work address: _____

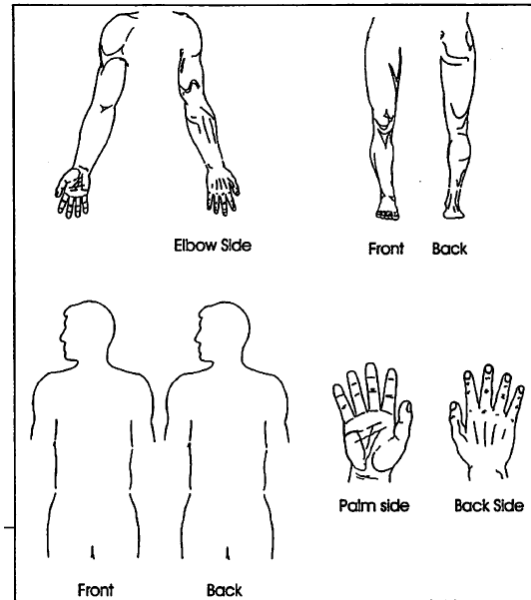
Phone: _____

Alternate Phone: _____

Statement:

Witness to record their statement in their own words or provide statement to be recorded and read back for verification – If additional space required, please attach pages to this report.

Please indicate on the diagram the area of injury:



(Witness's Signature)

(Date)

Injured employee's direct Manager's Signature

(Date)

Section D: INVESTIGATIVE REPORT

To be completed by injured employee's direct Manager and Certified Worker Representative

1. Description of occurrence:

2. Cause Analysis:

a) Direct causes (describe substandard conditions/actions which may have caused the occurrence):

b) Basic causes (describe the underlying job factors which may have caused the occurrence):

c) Recommended Corrective Action:

Responsible Individual/Department

Report Completed by:

Certified JHSC Worker Representative

SECTION E: CAUSE ANALYSIS (check all that apply)
To be completed by injured employee's direct Manager

Direct Causes: <ul style="list-style-type: none"><input type="checkbox"/> Substandard Conditions<input type="checkbox"/> Inadequate Protective Guards / Warning Devices<input type="checkbox"/> Defective Machinery, Equipment or Tools<input type="checkbox"/> Substandard Actions<input type="checkbox"/> Operating at Unsafe Speeds<input type="checkbox"/> Making Safety Devices Ineffective<input type="checkbox"/> Substandard PPE<input type="checkbox"/> Unauthorized Use of Equipment	Basic Causes: <p>Job Factors</p> <ul style="list-style-type: none"><input type="checkbox"/> Insufficient Supervision<input type="checkbox"/> Insufficient Work Procedures<input type="checkbox"/> Insufficient Training<input type="checkbox"/> Inadequate Purchasing<input type="checkbox"/> Inadequate Engineering Controls<input type="checkbox"/> Insufficient Maintenance<input type="checkbox"/> Abuse or Misuse	Personal Factors: <ul style="list-style-type: none"><input type="checkbox"/> Physical Restrictions<input type="checkbox"/> Inadequate Capability<input type="checkbox"/> Lack of Knowledge<input type="checkbox"/> Lack of Training<input type="checkbox"/> External Problems<input type="checkbox"/> Job Stress
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SECTION F: CORRECTIVE ACTION FOLLOW-UP
To be completed by injured employee's direct Manager

The purpose of this form is to ensure that the recommended corrective action has been taken to prevent future occurrences of the reported injury/incident.

Corrective Action:	Responsible:	Date Completed:
_____	_____	_____
_____	_____	_____
_____	_____	_____

Comments:

SECTION G: REPORT REVIEWED BY

_____	_____
Department Manager – PLEASE SIGN AND PRINT NAME (Injured employees direct manager)	Date
_____	_____
Management Co-Chair – JHSC – PLEASE SIGN AND PRINT NAME	Date
_____	_____
Worker Co-Chair – JHSC – PLEASE SIGN AND PRINT NAME	Date
_____	_____
Injured Employee – PLEASE SIGN AND PRINT NAME	Date

REPORT FORM DEFINITIONS

For more information please read **Subject 10.1 (A to J) Injury/Incident Investigations** from the Health and Safety Policies and Procedures Manual

FIRST AID INJURY – a minor injury requiring only first aid treatment.

MEDICAL AID INJURY – an injury requiring treatment by a health care professional.

LOST TIME INJURY – a disabling injury where the injured person is unable to report for the next regular shift.

PROPERTY DAMAGE ACCIDENT – accidental loss to equipment, material, and/or the environment.

INCIDENT (NEAR-MISS) – an undesired event that, under slightly different circumstances, could have resulted in personal injury, property damage or loss.

FATALITY OR CRITICAL INJURY:

For the purpose of this document, the following definitions will be used.

- A critical injury is any injury that: places life in jeopardy; causes unconsciousness; results in significant blood loss; involves the fracture of a leg, arm, foot, ankle, hand, wrist; involves the fracture of more than one finger, more than one toe, but not a single finger or not a single toe; involves amputating all or part of an arm or leg, but not a finger or a toe; consists of burns to a major portion of the body; or causes the loss of sight in an eye.
- A fatality is a death.

Steps to take if a Critical Injury occurs:

- The employee's immediate supervisor will contain the accident area to prevent further injury or damage and also to maintain it for investigation purposes.
- Emergency Response 911 will be contacted after securing the scene. Contact Director of Human Resources or designate.
- Contact the department head.
- Calls will be made by HR Director or designate immediately to the local MOL (Ministry of Labour) inspector, the Joint Health & Safety Committee, the union, police and the family.
- Within 48 hours, the Ministry of Labour Director will receive notification in the form of a written report describing what happened and giving any information that may be prescribed by the MOL.
- The supervisor is to complete the required form and provide to MOL containing the following information as per Section 51 of Safety Act:
 - the name and address of the constructor and the employer;
 - the nature and the circumstances of the occurrence and the bodily injury sustained;
 - a description of the machinery or equipment involved;
 - the time and place of the occurrence;
 - the name and address of the person who was killed or critically injured;
 - the names and addresses of all witnesses to the occurrence; and
 - the name and address of the physician or surgeon, if any, by whom the person was or is being attended for the injury.