

INCIDENT REPORT FORM

For Internal use. This form must be completed within 24 hours of the Board Chair hearing of the Incident.

<input type="checkbox"/> Injury		<input type="checkbox"/> First Aid		<input type="checkbox"/> Medical Aid		<input type="checkbox"/> No Injury		<input type="checkbox"/> Hazardous Situation	
THIS SECTION TO BE COMPLETED BY THE EMPLOYEE									
Who was hurt? <input type="checkbox"/> Employee <input type="checkbox"/> Visitor <input type="checkbox"/> Contractor <input type="checkbox"/> Other -Specify			Last name:		First name:		Phone:		
			Date and Time of Incident:		Date Reported:		Reported to:		
Description of Incident:							Type of Incident: <input type="checkbox"/> Slip*, trip or fall <input type="checkbox"/> Struck by/against object <input type="checkbox"/> Over exertion <input type="checkbox"/> Repetitive strain <input type="checkbox"/> Electrical contact <input type="checkbox"/> Exposure to hazardous material <input type="checkbox"/> Other (describe)		
*If this was a slip, describe footwear:									
Witnesses to the incidents: (names and phone numbers)									
What was the injury? (Indicate what part of the body):									
Did you see a medical professional? <input type="checkbox"/> Yes <input type="checkbox"/> No If YES, please provide name, address and phone number:					Treatment of Injury: <input type="checkbox"/> First Aid <input type="checkbox"/> Walk-In Clinic <input type="checkbox"/> Family Doctor <input type="checkbox"/> Emergency Room <input type="checkbox"/> Other (describe):				
THIS SECTION TO BE COMPLETED BY THE SUPERVISOR									
Contributing Factors: What conditions contributed to the incident?									
<input type="checkbox"/> Unsafe equipment		<input type="checkbox"/> Inadequate illumination		<input type="checkbox"/> Failure to use PPE		<input type="checkbox"/> Infraction or unsafe practice			
<input type="checkbox"/> Insufficient training		<input type="checkbox"/> Improper position/posture		<input type="checkbox"/> Insufficient care		<input type="checkbox"/> Hazardous Environment			
<input type="checkbox"/> Operating without authority		<input type="checkbox"/> Other							
Explanation of contributing factors:									
Details of property damage (if any):									
To your knowledge, has the person had a previous similar injury or has this similar hazard been reported before?									
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A									
Corrective Measures: Actions taken to prevent a reoccurrence (more than one item may apply):									
<input type="checkbox"/> Request job safety analysis		<input type="checkbox"/> On-the-job training		<input type="checkbox"/> Perform house-keeping		<input type="checkbox"/> Review PPE			
<input type="checkbox"/> Improve work procedure		<input type="checkbox"/> Check with manufacturer		<input type="checkbox"/> Retraining of person(s)		<input type="checkbox"/> Constructive discipline			
<input type="checkbox"/> Repair or replace equipment		<input type="checkbox"/> Install safety guard/device		<input type="checkbox"/> Other					
Explanation of corrective measures:									
Signature of Employee Reporting Incident:					Signature of Board Chair (or Designate):				
Date:					Date:				