



**Accident/Illness/Incident (AII) Reporting Form & Investigation**  
**Report FAX COMPLETED FORM (Within 24 hours) TO: 519-661-2079**  
**(82079) MAIL TO: Room 4159, Support Services Building, Rehabilitation Services**

**SECTION #1 – Accident/Illness/Incident Reporting Form**

**PART A**

Name of Employee: \_\_\_\_\_ Employee Number: \_\_\_\_\_

Contact Telephone Number of Employee: (Home) \_\_\_\_\_ (Cell) \_\_\_\_\_

Employee Group(if applicable):  UWOSA  PMA  CUPE 2361  CUPE 2692  IUOE  PSAC 610  SAGE  UWOFA  
 UWOPA

Status:  RF  RP/TM  CW  Undergrad Student  Grad Student  Other/Visitor

Type:  Occ. Illness  Accident  Incident  No Injury/Hazard  First Aid  Lost Time  Non-Lost Time

**PART B**

Date & Time of AII: \_\_\_\_\_ Time: \_\_\_\_\_ a.m/p.m.  
Day/Month/Year

Date & Time AII Reported: \_\_\_\_\_ Time: \_\_\_\_\_ a.m/p.m.  
Day/Month/Year

Description of Accident/Illness/Incident:(What happened to cause the AII? What was the person doing? Was there any equipment, people or materials involved- identify the size, weight and type)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Part of body injured (specify left or right side):

\_\_\_\_\_

\_ Location/Area of AII or Hazardous Situation (Building and Rm #):

\_\_\_\_\_

Name & Contact Information of Witness(es): \_\_\_\_\_

*(If there are witnesses, please include a statement from each witness)*

**PART C**

Treatment of Injury:

1. Did the Employee/Student receive First Aid and by whom? YES  NO

If YES, give treatment details: \_\_\_\_\_

2. Did the Employee/Student visit Workplace/Student Health? YES  NO

3. Did the Employee visit Hospital and/or Physician? YES  NO

If YES, what hospital/physician, date & time, address, phone number & give transportation details(e.g. ambulance) :

\_\_\_\_\_

To your knowledge, has the person had a similar disability? If YES, please explain below YES  NO

\_\_\_\_\_

## SECTION #2 – Investigation Report

### **PART D**

**Immediately investigate if any of the following occur: Fatalities, Critical Injuries, Lost Time, Occupational Illness, Property Damage, Fire or Environmental Release**

Is the employee off work due to this AII ?

Yes    No

Date & Hour Last Worked: \_\_\_\_\_ a.m./p.m.  
Day/Month/Year/Time

Normal Working Hours & Days:

	Sun	Mon	Tue	Wed	Thu	Fri	Sat
Time							
Hours							

Employee Return to Work Date: \_\_\_\_\_ a.m./p.m.  
Day/Month/Year/Time

### **PART E**

**Contributing Factors (Check  applicable factors):**

- Hazardous method/procedure used
- Improper position/posture (ergonomics)
- Inadequate personal protective equipment
- Incorrect/defective tools
- Unsafe design or construction
- Poor weather conditions
- Hazardous housekeeping or arrangement
- Inexperience of person in the task
- Training/job instruction inadequate

- Inadequate guarding of material & equipment
- Inadequate lighting/ventilation
- Other: \_\_\_\_\_

Detail Factors: \_\_\_\_\_

**Actions and Follow up to prevent Recurrence:**

- Contact Occupational Health & Safety for assistance
- Contact Physical Plant Department for assistance
- Actions to improve design/procedures
- Correct congested area
- Repair or replace tool/equipment
- Improve personal protective equipment
- Install guard or safety device
- Reinstruct person involved & provide support/coaching
- Request Ergonomic Assessment
- Update training
- Refer to Rehabilitation Services

**\*\* Supervisor to provide a detailed Action Plan below\*\***

### **ACTION PLAN**

**Action Plan**(include what, why & how recommendations are made)

**Party Responsible**

**Completed Date**

**Follow Up**

**PART F**

<b>INVESTIGATED BY:</b>	
Name of Supervisor: _____ (print name) Telephone Number: _____	
Supervisor Signature: _____	Date: _____
<b>REVIEWED BY:</b>	
Management (Department Chair or Unit Head) Signature:	
_____	Date: _____
Employee Signature: _____	
_____	Date: _____
JOHSC Rep Signature: _____	
<i>(if applicable)</i>	Date: _____
OHS Signature: _____	
<i>(if applicable)</i>	Date: _____

**\*\*FAX COMPLETED FORM TO 519-661-2079 OR EXT 82079 (ON CAMPUS)\*\***

**PART G Distribution List:**

**Initial - Sent Off:**

**Distribute copies to:**  
**(Supervisor to do)**

- |  |       |
|--|-------|
| 1) Workplace/Student Health Services (UCC 25)          | _____ |
| 2) Budget Unit Head/Supervisor or Chair                | _____ |
| 3) Employee/Student/Visitor                            | _____ |
| 4) Originator  | _____ |
| 5) Applicable Employee's Union/Staff Group – JOHSC Rep | _____ |
| UWOSA-UCC 255  | _____ |
| PMA-UCC 351  | _____ |
| CUPE 2361 FM-SSB 1320                                  | _____ |
| CUPE 2692 HS -Perth Hall 152                           | _____ |
| UWOPA-LwH 1257   | _____ |
| IUOE   | _____ |
| PSAC 610-UCC 270                                       | _____ |
| SAGE-STvH 3107P  | _____ |
| UWOFA-ELBORN   | _____ |



