



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 ☐ UWOPA
☐ 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: _____
Day/Month/Year

Time: _____ a.m/p.m

Date & Time AII Reported: _____
Day/Month/Year

Time: _____ a.m/p.m.

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

INVESTIGATED BY:

Name of Supervisor: _____ (print name) Telephone Number: _____

Supervisor Signature: _____ Date: _____

REVIEWED BY:

Management (Department Chair or Unit Head) Signature:

_____ Date: _____

Employee Signature: _____ Date: _____

JOHSC Rep Signature: _____ Date: _____
(if applicable)

OHS Signature: _____ Date: _____
(if applicable)

****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	_____

WITNESS STATEMENT *(Include for each witness when submitting AIIR)*

Name of Witness: _____

Contact Information: _____

Phone/Ext: _____

Date and Time of Accident/Incident: _____

Injured Worker's Name: _____

Location of Accident/Incident: _____

Your Account of the Accident/Incident:

This image shows a blank sheet of white paper with horizontal ruling lines. The lines are evenly spaced and run across the width of the page. There are no margins, text, or other markings on the paper.

Name of Witness: _____

Date: _____

Signature of Witness: _____

[illegible]

Date: _____

Signature: _____