

Employee Incident Report

Employee Information	Last Name _____ _____		Home Telephone No. _____ (_____) (_____) (_____)	
	First Name _____ _____		Work Telephone No. _____ (_____) (_____) (_____)	
	Date of Birth (DD/MM/YY) _____ ____/____/____		Employee ID# _____ / SIN _____ (_____) (_____) (_____)	
Address _____ _____ City/Town _____ Province _____ Postal Code _____ (_____) (_____)				
Division/Dept./Unit _____ Occupation at time of Injury _____			Check: <input type="checkbox"/> Full-time <input type="checkbox"/> Casual <input type="checkbox"/> Part-time <input type="checkbox"/> Student _____ Years of Experience <input type="checkbox"/> YES <input type="checkbox"/> NO	
Description of Incident	Date of Incident (DD/MM/YY) _____ ____/____/____		Date Reported (DD/MM/YY) _____ ____/____/____	
	Time of day _____ AM/PM		Time of day _____ AM/PM	
	State the exact sequence of events leading up to the incident. Include an explanation of what the employee was doing. _____ _____ _____ _____ _____		To whom was the incident reported? _____ If report is delayed, please explain why. _____ _____	
	Did the accident happen on the employer's premises? _____ What caused the injury/illness? _____ _____ _____		Identify the sizes, weights & types of equipment involved. _____ _____ Type of Incident (check one—definitions on reverse): 1 <input type="checkbox"/> Struck/Caught 2 <input type="checkbox"/> Overexertion 3 <input type="checkbox"/> Repetition 4 <input type="checkbox"/> Fire/Explosion 5 <input type="checkbox"/> Fall 6 <input type="checkbox"/> Harmful Substances/Environmental 7 <input type="checkbox"/> Assault 8 <input type="checkbox"/> Other 9 <input type="checkbox"/> Slip/Trip 10 <input type="checkbox"/> Motor Vehicle Incident	
Witnesses	Names, positions, & phone numbers of witnesses or persons having knowledge of the incident. _____ _____			
Cause	Was the accident/illness: 1 <input type="checkbox"/> A Sudden, Specific Event/Occurrence? 2 <input type="checkbox"/> Gradually Occurring Over Time? 3 <input type="checkbox"/> An Occupational Disease? 4 <input type="checkbox"/> A Fatality? Direct causes (check one – see reverse): 1 <input type="checkbox"/> Physical/Environmental 2 <input type="checkbox"/> Personal Basic causes (check one): 1 <input type="checkbox"/> Job factors 2 <input type="checkbox"/> Personal factors			
Correction	Action(s) Taken 1 _____ 2 _____ 3 _____ 4 _____ 5 _____ 6 _____ 7 _____		CORRECTED (check box) <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	PLANNED (check box) <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
	Date (DD/MM/YY) ____/____/____ ____/____/____ ____/____/____ ____/____/____ ____/____/____ ____/____/____		Examples of Actions: 1. Reinstruction of person involved 2. Reassignment of person 3. Order job safety analysis done 4. Improve personal protective equipment 5. Action to improve inspection 6. Equipment repair or replacement 7. Correction of congested area 8. Installation of guard or safety device 9. Actions to improve design/procedure 10. Check with manufacturer 11. Inform all department supervisors 12. Discipline of persons involved 13. Other: _____	
Injury	Describe the illness or injury, part of body involved and specify left or right side. _____ _____			
	Are you aware of any prior similar or related problem, injury, or condition? If yes, please explain: _____ _____			
Occupational Health	No injury (check one) 1 <input type="checkbox"/> Hazardous situation		Injury – No WSIB Claim (check one) 1 <input type="checkbox"/> First aid 2 <input type="checkbox"/> No aid	
	Did employee seek medical attention? (check one) 1 <input type="checkbox"/> No 2 <input type="checkbox"/> Yes Did employee visit health service? (check one) 1 <input type="checkbox"/> No 2 <input type="checkbox"/> Yes Did employee visit emergency? (check one) 1 <input type="checkbox"/> No 2 <input type="checkbox"/> Yes If Yes, ER Physician's Name _____ Tel.No. (_____) _____ (_____) (_____) (_____)		Did employee visit family physician? (check one) 1 <input type="checkbox"/> No 2 <input type="checkbox"/> Yes If Yes, Physician's Name _____ Tel.No. (_____) _____ (_____) (_____) (_____)	
	Will the employee undertake: (check one) 1 <input type="checkbox"/> Regular duties 2 <input type="checkbox"/> Modified duties 3 <input type="checkbox"/> Remain off work		Has the employee had a similar disability? (check one) 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Unknown	
	Check attachments to this report. 1 <input type="checkbox"/> Statements 2 <input type="checkbox"/> Photographs 3 <input type="checkbox"/> Treatment memo 4 <input type="checkbox"/> Other – specify: _____			
EMPLOYEE SIGNATURE _____ Date _____		MANAGER SIGNATURE _____ Date _____		OCC. HEALTH DEPT. SIGNATURE _____ Date _____

This Information is to be used for completion of WSIB Claim Form 7

01801010810-IRSI-RF-00AEN01810

Instructions for Completion

Employee Incident Report

The purpose of this report is to:

- Collect factual data relating to the occurrence of a workplace injury
- Collect data for completion of the WSIB report
- Provide a systematic means to record incidents, document the results of investigations and note how, when and what corrective action will be taken
- Help to ensure the provision of prompt medical treatment
- Assist in the determination of the causative factors related to the incident
- Systematically collect factual data for statistical records
- Guide the investigator in conducting an effective investigation

ORIGINAL to be kept in "Employee Incident Report" file in H&S area/division

2ND COPY to injured worker's supervisor

3RD COPY to injured worker's occupational health or employee file

NOTE: Shaded information is considered confidential and should not be shared with the joint health and safety committee.

Types of Incidents - Definitions

Struck/Caught

- An incident in which a person has been struck abruptly or forcefully by some object in motion (e.g., box falls off shelf, employee jabs needle into finger, person pushing cart runs into someone) or a person is contacted non-forcefully by some substance or agent in motion that has an injury-upon-contact characteristic (such as being splashed by hot or corrosive solutions).
- An incident in which a person strikes abruptly or forcefully some stationary object in his/her surroundings (e.g., nurse strikes his/her leg against the crank of a bed) or comes into contact, non-forcefully, with some stationary substance or agent that has an injury-upon-contact characteristic (such as electrical shock).
- An incident in which a person is:
 - a. trapped in some type of enclosure or a part of a person's body is caught in some type of opening (e.g., a person is caught in an elevator or locked into a refrigerated room)
 - b. caught on some protruding object (e.g., a person's clothing gets hooked onto a handle or a person catches his/her hand on a sharp edge)
 - c. pinched, crushed or otherwise caught between either a moving object and a stationary object or between two or more moving objectives (e.g., a person jams his/her fingers between a wheeled cart and doorway).

Fall

A fall on the same level on which a person was standing or walking, or when a person falls to below the level on which he/she was standing or walking.

Slip/Trip

The person either slips or trips but does not fall.

Overexertion

An incident is one in which a person puts excessive strain on some part of his/her body (e.g., an employee strains his/her back or some other part of the body).

Harmful Substances/Environmental

An incident in which the employee is exposed to harmful conditions (e.g., toxic gases, fumes or vapours; toxic airborne particles; extremes of heat or cold; oxygen deficient atmospheres; radioactive radiation; intense light brightnesses, infectious diseases, blood/blood-stained body fluids, moulds/spores).

Assault

An incident in which the employee is subjected to an untoward action by a patient or member of the public (e.g., a patient bites or strikes an employee).

Repetition

An incident that develops over a period of time due to the repetitive nature of the task being carried out (e.g., pipetting, keyboarding).

Fire/Explosion

An incident in which the employee is subjected to a fire or explosion in the workplace.

Motor Vehicle Incidents

An incident in which the employee is involved in a motor vehicle incident during the course of his/her work activities.

Direct Causes - Definitions

Physical/Environmental

Contributing conditions such as machinery/equipment, house-keeping, physical agents, chemical agents, personal protective equipment, temperature (heat/cold), etc.

Personal

Contributing actions such as unauthorized equipment use, improper body motion, working at unsafe speeds.

Basic Causes - Definitions

Job Factors

Work procedures, purchasing, design, training, engineering controls, etc.

Personal Factors

Physical restrictions, lack of training, motivation, inadequate capability, etc.