

Incident Investigation Report

1. Employer's information

Employer's name (legal name and trade name) University of Northern BC	Operating location number 001	WorkSafeBC account number 431796
Employer's head office address 3333 University Way		
City Prince George	Province BC	Postal code V2M 4Z9
Reported to	Date Reported (mm/dd/yyyy)	Time Reported
<input type="checkbox"/> Reported to Security <input type="checkbox"/> Form 7 Completed <input type="checkbox"/> WCB Notified (As required by Act) <input type="checkbox"/> Form 6A Completed	<input type="checkbox"/> First aid <input type="checkbox"/> Medical aid <input type="checkbox"/> Near Miss	First aid or Medical aid was provided by:

2. Injured persons

Last name	First name	Job title
<input type="checkbox"/> UNBC Employee	<input type="checkbox"/> Student	<input type="checkbox"/> Apprentice/Practicum
<input type="checkbox"/> Contractor	Company	

3. Place, date, and time of incident

Location where incident occurred (Campus, Building, room number)	
Date of incident (m/d/yyyy)	Time of incident <input type="checkbox"/> a.m. <input type="checkbox"/> p.m.
<input type="checkbox"/> Incident occurred during normal working shift	Other Notes for Section 3::

4. Type of occurrence (select all that apply)

<input type="checkbox"/> Death of a worker <input type="checkbox"/> Serious injury to a worker (More than first-aid required) <input type="checkbox"/> Minor injury to worker (required first-aid) <input type="checkbox"/> Major release of hazardous substance <input type="checkbox"/> Near Miss (No Injury but potential to cause injury) <input type="checkbox"/> Excavation <input type="checkbox"/> Lockout	<input type="checkbox"/> Confined Space <input type="checkbox"/> Fall from height <input type="checkbox"/> Incident of fire or explosion <input type="checkbox"/> Minor injury or no injury but had potential for causing serious injury <input type="checkbox"/> Workers right to refuse work <input type="checkbox"/> Other (Please specify):
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An incident investigation report is NOT required under the *Workers Compensation Act* if none of the above applies or if this incident is a vehicle accident occurring on a public street or highway.

5. Report type (select all that apply) If this is a revised version of a previous report, please check here ☐.

<input type="checkbox"/> Preliminary Investigation Report If requested only, provide a copy to WorkSafeBC.	<input type="checkbox"/> Interim Corrective Action Report	<input type="checkbox"/> Full Investigation Report Must be provided to WorkSafeBC within 30 days* Fax 1.866.240.1434	<input type="checkbox"/> Full Corrective Action Report
Report date (mm/dd/yyyy)	Report date (mm/dd/yyyy)	Report date (mm/dd/yyyy)	Report date (mm/dd/yyyy)
Officer's name		Date sent (mm/dd/yyyy)	

6. Witnesses

Last name	First name	Job title
a)		
b)		
c)		

7. Other persons whose presence might be necessary for proper investigation

Last name	First name	Job title
a)		
b)		

8. Sequence of events that preceded the incident

Required in Preliminary Report. Update in Full Report if necessary. Describe events earlier that day or even in previous years that led up to the incident. Examples may include events such as training given or changes in equipment, procedures, or company management.

9. Unsafe conditions, acts, or procedures that significantly contributed to the incident

Required in all reports. Describe anything, or the absence of anything, that contributed to the incident.

Contributing Factors: <input type="checkbox"/> Lifting <input type="checkbox"/> Slip or Trip <input type="checkbox"/> Twist <input type="checkbox"/> Fall <input type="checkbox"/> Lack of or not following procedures <input type="checkbox"/> Poor visibility/lighting <input type="checkbox"/> Training not provided/Insufficient knowledge of task <input type="checkbox"/> Supervisor unaware of task being done or hazard of task <input type="checkbox"/> Failure to recognize hazard <input type="checkbox"/> Rush job <input type="checkbox"/> Sharp edge	<input type="checkbox"/> Over exertion <input type="checkbox"/> Struck <input type="checkbox"/> Harmful substance <input type="checkbox"/> Repetitive (actively repeated) <input type="checkbox"/> Crush <input type="checkbox"/> Fire or explosion <input type="checkbox"/> Not using or defective PPE <input type="checkbox"/> Defective tools <input type="checkbox"/> Housekeeping <input type="checkbox"/> Equipment failure <input type="checkbox"/> Unstable load <input type="checkbox"/> Other (specify)
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10. Nature of the serious injury (optional — complete only if there has been an injury)

- | | |
|---|--|
| <input type="checkbox"/> Life threatening or resulting in loss of consciousness | <input type="checkbox"/> Burns |
| <input type="checkbox"/> Major broken bones in head, spine, pelvis, arms, or legs | <input type="checkbox"/> Cuts/scrapes, not severe bleeding |
| <input type="checkbox"/> Major crush injuries | <input type="checkbox"/> Dislocation |
| <input type="checkbox"/> Major cut with severe bleeding | <input type="checkbox"/> Respiratory |
| <input type="checkbox"/> Amputation of arm, leg, or large part of hand or foot | <input type="checkbox"/> Internal bleeding |
| <input type="checkbox"/> Major penetrating injuries to eye, head, or body | <input type="checkbox"/> Serious chemical or heat/cold stress exposure |
| <input type="checkbox"/> Hospitalization | <input type="checkbox"/> Bruising |
| <input type="checkbox"/> Time lost from work | <input type="checkbox"/> Needle stick |
| <input type="checkbox"/> Occupational Disease Date of Exposure | <input type="checkbox"/> Other (specify) |

11. Description of the incident

Required in Preliminary Report. Briefly, summarize the sequence of events, the unsafe factors, and the resulting injury, if any.

- ☐ Photos or other attachments
- ☐ Security Incident Report Attached

12. Corrective actions identified and taken to prevent recurrence of similar incidents

Action (Required in Preliminary Report and Interim Corrective Action Report. Update in Full Report, if necessary.)	Action assigned to (name and job title)	Expected completion date (mm/dd/yyyy)	Completed date (mm/dd/yyyy)
a)			
b)			
c)			
d)			
e)			

13. Explanation of blank areas on this Preliminary Report, if any

If there are blank areas, describe the circumstances beyond your control that explain this lack of information.

14. Persons who carried out or participated in the preliminary investigation

Representative	Name	Job title	Signature (optional)	Date signed (mm/dd/yyyy)
Employer representative				
Worker representative				
Other				
Other				

End of preliminary report

Completing all the sections above satisfies the requirements for a Preliminary Investigation Report and an Interim Corrective Action Report.

Note: If this was a simple investigation and **all needed corrective actions have been completed within 48 hours**, the Preliminary and Full Investigation portions of the report can be completed at the same time. If so, you can check both the Preliminary Investigation Report and the Full Investigation Report boxes in section 5.

Copies of **all** reports must also be provided to the joint occupational health and safety committee or worker representative, as applicable.

15. Determination of causes of incident

Required in Full Report. Analyze the facts and circumstances of the incident to identify underlying factors that led to the incident. Underlying factors include factors that made the unsafe conditions, acts, or procedures in the Preliminary Report possible. Update items from section 9, if needed.

16. Full description of the incident

Required in Full Report. Use the brief description from the Preliminary Report and update it, if necessary.

17. Additional corrective actions necessary to prevent recurrence of similar incidents

Additional corrective action (Required in Full Report and Full Corrective Action Report.)	Action assigned to (name and job title)	Expected completion date (mm/dd/yyyy)	Completed date (mm/dd/yyyy)
a)			
b)			
c)			
d)			

18. Persons who carried out or participated in the full investigation

Representative	Name	Job title	Signature (optional)	Date signed (mm/dd/yyyy)
Employer representative				
Worker representative				
Other				

19. Other relevant workplace parties

Company name	Contact person	Contact number or email address
a)		

End of full report

Completing all the sections above satisfies the requirements for a Full Investigation Report and a Full Corrective Action Report.

Employers are required to submit **full** investigation reports to WorkSafeBC **within 30 days* of the incident**. * Employers can request an extension from a WorkSafeBC officer, **if the full investigation cannot be completed within 30 days**.

Copies of **all** reports must also be provided to the joint occupational health and safety committee or worker representative, as applicable.