ACCIDENT / INCIDENT INVESTIGATION REPORT

GUIDE TO COMPLETING THE ACCIDENT/INCIDENT INVESTIGATION REPORT FORM

Definition of Incident: An unplanned event that results in, or could result in, an injury or fatality, or damage/destruction of equipment, property or the environment.

Incidents may result in one or more of the following:

- **Near-Miss**: An incident that does not result in an injury
- **First-Aid**: Treatment such as ice packs, bandages or eyewash flushing, etc.
- **Medical Aid**: Treatment or examination by a physician, dentist, chiropractor, physiotherapist, emergency room attendant or similar health care practitioner.
- **Lost Time**: Unable to attend the next regularly scheduled shift of work

This form must be completed and sent to your supervisor or Brescia contact ASAP, so that it can be reviewed and forwarded to the proper authorities **WITHIN 72 HOURS** of the incident

Instructions for the Person Involved in the Incident:

- Check the appropriate box under the Incident Classification section
- Continue with relevant sections, as outlined below;
  - **Employees** complete sections **A, B, C, F, G, I**
  - **Students** complete Sections **A, B, D ,F, G ,I**
    - Attach Work/Education Placement Agreement if student is on placement
  - **Visitors** and **Contractors** complete Sections **A, B, E, F, G, I**
  - **Witnesses** complete section **J**
- If an incident later escalates into a medical aid or lost time, you must notify your Supervisor or Brescia contact of this change

Instructions for Supervisors and other Brescia Contacts:

- Review the completed form, as submitted by the person involved in the incident.
- Complete Sections H and I
- Attach any additional information relevant to this incident (witness statements, MSDS info sheets, etc.)

For Further Information:

- Contact: Ingrid Christensen, Payroll & Benefits,
  Room 153, 1285 Western Road
  London, On, N6G 1H2
- Telephone (519) 432-8353 ext. 28208; Fax: (519) 858-5116; E-mail: ingrid.christensen@uwo.ca

EMPLOYEE RESPONSIBILITIES

1. Promptly receive first aid.
2. Notify your supervisor immediately of any injury, including injuries which do not require medical attention or lost time.
3. Choose a doctor or other qualified practitioner (hospital, physician, chiropractor, physiotherapist, registered nurse -extended class, dentist).
4. Complete and return all report forms received from the WSIB.
5. In the case of a lost time injury, keep your supervisor updated as to your progress.

SUPERVISOR RESPONSIBILITIES

1. Ensure that first aid is received.
2. Provide transportation for the employee to a medical facility or to their home.
3. Investigate the accident and determine causes and make necessary changes.
4. Send a completed accident report to the Payroll Office within 24 hours.

CRITICAL INJURY IS DEFINED AS AN INJURY OF A SERIOUS NATURE THAT:

(a) Places a life in jeopardy.
(b) Produces unconsciousness.
(c) Results in substantial loss of blood.
(d) Involves the fracture of a leg or arm but not a finger or toe.
(e) Involves the amputation of a leg, arm, hand or foot, not a finger or toe.
(f) Consists of burns to a major part of the body.
(g) Causes the loss of sight in an eye.

IN THE EVENT OF A CRITICAL INJURY, SUPERVISORS ARE RESPONSIBLE FOR:

1. Arrange for immediate medical attention.
2. Notifying – UWO Campus Police at: 978-2222

- Ministry of Labour (8:30 a.m. to 5:00 p.m.): 416-314-5421 or 1-800-991-7454
  (Nights/Weekends/Holidays): 416-325-3000 or 1-800-268-6060
- Representative from the Joint Health and Safety Committee.
- Human Resources Ingrid Christensen 519-432-8353 ext. 28208
- Worker Representation Adam Cake 519-432-8353 ext. 28267

. Ensuring the site of the accident remains undisturbed until a Ministry of Labour inspector has arrived.

4. Preparing a written report of the circumstances of the accident.

ACCIDENT/INCIDENT INVESTIGATION REPORT

Brescia University College
1285 Western Road
London, Ontario Canada N6G 1H2

****RELEVANT SECTIONS MUST BE COMPLETED IN FULL BY EMPLOYEE'S SUPERVISOR****
SUBMIT WITHIN 24 HOURS TO: PAYROLL OFFICE OR FAX: 519-858-5116

Person involved:	☐ Employee	☐ Student	☐ Contractor	☐ Visitor
Sections to complete:	A, B, C, F, G, I	A, B, D, F, G, I	A, B, E, F, G, I	A, B, E, F, G, I
Supervisor: Ensure all sections are completed, including H and I				

A. ACCIDENT / INCIDENT CLASSIFICATION

☐ First Aid (no medical treatment required)
☐ Medical Aid (medical treatment required)
☐ Lost Time (medical treatment required & absent
☐ Near Miss (no injury)
☐ Hazardous Situation
☐ Recurrence, if previous injury (provide claim # If possible)_____

B. PERSONAL INFORMATION OF PERSON INVOLVED

Full Name_____ ☐ Male ☐ Female
S.I.N.:_____ Date of Birth (d/m/y) _____
Address_____ Telephone (include area code)_____
City_____ Province_____ Postal Code _____

C. EMPLOYEES TO COMPLETE THIS SECTION

Name of Supervisor_____ Department_____
Job Title_____ Length of Time in Position_____ Hire Date(d/m/y)_____
Normal work days and hours_____

D. STUDENTS TO COMPLETE THIS SECTION

Student Number_____ Campus Location_____
Was the incident program related? ☐ Yes ☐ No
Did the incident occur on placement? ☐ Yes ☐ No If yes, is this a paid placement ☐ Yes ☐ No
If yes, name and phone # of placement employer _____

E. CONTRACTORS and VISITORS TO COMPLETE THIS SECTION

☐ Contractor ☐ Visitor
College Contact_____
Company Name and Address _____
Reason for being at Brescia College University_____

F. INCIDENT INFORMATION

Date of Incident (d/m/y)_____ Time_____ a.m./ p.m

Date Reported (d/m/y)_____ Time_____ a.m./ p.m

Reported to_____ Position_____ Telephone ( )_____

Individual(s) witnessing or having knowledge of the incident _____

Location (campus/building/room/other) _____

Description of Incident (What happened? What was the task/activity? Were there any people, equipment or materials involved?

Identify the size, weight and type) _____

Was the Incident/Illness: ☐ Sudden Specific ☐ Gradually Occurring Over Time

Type of Incident/Illness: (Please select ONE only)

☐ Cut/ Scrape	☐ Overexertion	Needle stick/Puncture	Burn
☐ Slip/Trip	☐ Repetitive	Assault	Fire/Explosion
☐ Fall	☐ Struck/Caught	Harmful Substances/Environment	Motor Vehicle

Area of Injury (Body Part) – Please check all that apply

☐ Head	☐ Teeth	☐ Upper back	Left Right	Left Right	Left Right	Left Right
☐ Face	☐ Neck	☐ Lower Back	☐ Shoulder ☐	☐ Wrist ☐	☐ Hip ☐ ☐	☐ Ankle ☐
☐ Eye(s)	☐ Chest	☐ Abdomen ☐	☐ Upper Arm ☐	☐ Hand ☐	Thigh ☐	☐ Foot ☐
☐ Ear(s)		Pelvis	☐ Elbow ☐	☐ Fingers ☐	☐ Knee ☐	☐ Toe(s) ☐
			☐ Forearm ☐		☐ Lower Leg ☐	

☐ Other _____

Have you had any prior similar problem? Please clarify._____

G. FIRST AID, HEALTH CARE AND LOST TIME/NO LOST TIME

Describe first aid treatment, if applicable:

_____

_____

_____

_____

For medical aid and lost time, provide the following:

Name of attending doctor/facility_____

Address _____

Telephone (include area code) _____

Date seen (d/m/y) _____

Provide the date the college learned of medical attention (d/m/y)_____

After the date of incident, **have you lost any time or earnings from your job/placement/classes?** ☐ Yes ☐ No

Start date of lost time (d/m/y)_____ Date of return (d/m/y)_____ Returned to Regular Modified

Has an Absence Report been forwarded to HR identifying WSIB Lost Time? Yes No

H. SUPERVISOR'S INCIDENT FOLLOW-UP AND ACTION PLAN

What were the causes of the incident? (Consider contributing factors, conditions, unsafe acts, personal/job factors.)

Was personal protective equipment used at the time? Please clarify

Was Property damaged (vehicle/equipment/materials)? Please clarify

Supervisor Action Plan (Describe action to be taken to prevent reoccurrence, and any recommendations)

Action Plan (include what and why recommendations are made)	**Party Responsible**	**Completed Date**	**Follow Up**

Supervisor Responsible Date (d/m/y)

I. SIGNATURES – E-mail completed document, within 24 hours of the incident, to: 1) Ingrid Christensen (ingrid.christensen@uwo.ca) 2) Supervisor 3) Person Involved

Person Involved (print clearly) Department

Signature Date (d/m/y)

Supervisor or Brescia Contact (print clearly) Department

Signature Date (d/m/y)

FOR OFFICE USE ONLY:
Reviewed by H&S (print clearly) Date (d/m/y)
Signature

J. WITNESS STATEMENT FORM

Name of Witness:	(print)
Contact Information:	
Phone/Ext:	
Date and Time of Accident/Incident:	
Injured Worker's Name:	
Location of Accident/Incident:	
Witness's Account of the Accident/Incident:	
Signature of Witness:	Date: