

# Employee Incident Report

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

# 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 Accidents

An incident in which the employee is involved in a motor vehicle accident 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.