**Employee Incident/Injury Report Form Form #**

**(Must be Reported Within 24 Hours of Incident to Supervisor)**

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| **Part A** | **Employer Information** |

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| **(Enter School Division)** | |
| Name of School/Facility: |  |

**Employee Information**

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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Employee Name: |  | | | | | | | | | | | |
| Type of Employment: | |  | Full Time | |  | Part Time | |  | Casual | |  | Other |
| Home Phone Number: | |  | | | | | Work Phone Number: | | |  | | |
| Occupation at Time of Incident/Injury: | | | |  | | | | | | | | |

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| **Part B** | **Incident/Injury Information** |

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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Type of Incident | | | | | | |  | Property Damage | | | | | | | | | |  | Injury | | | |  | Near Miss |
| Date of Incident/Injury (mm/dd/yy) | | | | | | | | |  | | | | | | | | | | | | | | | |
| Time: |  | | | |  | am | | | | |  | | pm | | | | | | | | | | | |
| Date Reported: | | |  | | | | | | | | | | | | | | | | | | | | | |
| Time: |  | | | |  | am | | | | |  | | pm | | | | | | | | | | | |
| Whom was the Incident/Injury Reported to? | | | | | | | | | | | |  | | | | | | | | | | | | |
| Position: | |  | | | | | | | | | | | | | | | | | | | | | | |
| Medical Care Required? | | | | | | |  | Yes | | | | | | |  | | No | | | |  | Don’t Know | | |
| Heath Care Provider Name: | | | | | | |  | | | | | | | | | | | | | | | | | |
| Were there any witnesses to the incident/injury: | | | | | | | | | | | | | |  | | Yes | | | |  | No | | | |
| Please Provide the Witness(s) Name(s): | | | | | | | | | |  | | | | | | | | | | | | | | |
| Work Time Lost: | | | |  |  | Yes | | | | |  | | No | | | | | | | | | | | |
| If Yes, Date of 1st Full Day Lost: | | | | | | |  | | | | | | | | | | | | | | | | | |

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| Incident Description: State the sequence of events leading up to the incident, where it occurred, what was the activity, job, or process being performed? Equipment being used? What type of Personal Protective Equipment (PPE) was used, if any? Were any hazardous products being used? | | | | | | | | | |
|  | | | | | | | | | |
| Suggestions on how this could have been prevented? | | | | | | | | | |
|  | | | | | | | | | |
| Body Part Injured: |  | | |  | Right |  | Left | | |
| Signature of Employee: | |  | | | | | | Date: |  |
| Signature of Supervisor: | |  | | | | | | Date: |  |
| Human Resources Area: | |  | | | | | | Date: |  |
| Reviewed at Meeting Date: | | |  | | | | |  |  |
| OHC Recommendations: | |  | | | | | | Date: |  |
| Signature of Co-Chair(s) | |  | | | | | | | |

*Definition of a worker: an individual, including a supervisor, whom is engaged in the service of an employer, or a member of a prescribed category of individuals.*