EMPLOYEE INCIDENT / INJURY REPORT FORM

Name: _____ **Date:** _____ **Start / End Time** _____ **Location/Department** _____

Occupation: (circle one)

Staff Student Visitor Volunteer Contracted worker Other _____

Address: _____ **City/Town:** _____ **Postal Code:** _____ **Age:** _____ **Sex:** _____

Date and Time Incident Occurred _____

Date Incident was reported to Supervisor: _____

Nature of injury (i.e. cut, sprain, burn) _____

Part of body Injured (i.e. lower back, right hand index finger, left foot)

_____

Degree of Injury (circle one) Record only Medical Only Lost Time

Cause of injury _____

_____

Location of incident (i.e. schools grounds, science lab, industrial arts) _____

Activity of person injured _____

_____

Why did the incident occur _____

_____

What could have prevented the incident _____

_____

Corrective Action Taken or Recommended _____

_____

_____

Was the Incident witnessed Yes No By Whom _____

Was First Aid Required Yes No Name of First Aider _____

_____ _____ _____

Employee's Name Employee's Signature Date

_____ _____ _____

Administrator/Supervisor Name Signature Date

Workplace Safety and Health Committee Review and Recommendations

_____ _____ _____

Co-Chair Employer Signature Date

_____ _____ _____

Co-Chair Worker Signature Date

When form is completed please attach to first aid report and forward to site administraion, co-chair employer member of the safety committee and safety coordinator