



ACCIDENT/INCIDENT REPORT

(Reference Policy: HR 405 – Occupational Health & Safety)

Date: _____ Time: _____

Insurance Claim: Yes _____ No _____

WCC Claim: Yes _____ No _____

Name: _____ Student _____ or Staff _____

Campus: _____ Student # (If applicable) _____

Nature of Incident/Accident: (A Brief description of how it happened)

Location:

Injuries:

Treatment(s):

Witnesses: _____

Referral to: _____ Hospital (Hospital Name)
_____ Family Doctor _____ Home _____ No Referral

Means of Transportation: _____ Ambulance _____ Taxi _____ Other
(Please Specify)

Recommendations to avoid this type of accident in future:

Date

Casualty's Signature

Name of individual who applied First Aid and Date
(Please Print)

Signature

Name of administration Manager and Date
(Please Print)

Signature

Copy: Human Resources Manager or Student Counsellor (as appropriate)
Occupational Health and Safety Officer
Facilities Manager