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 Casuality’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