Form 1 Incident Report

Instructions:

Form 1, to be completed by employee when possible, to immediately report Incident to your supervisor. Supervisor verifies information, signs off and submits to assigned HR representative immediately, in no case later than 24 hours of incident.

Form 2, to be completed by supervisor, or investigation team, to conduct the Incident Investigation.

Confidentiality - The Occupational Health and Safety Office is collecting this information for the purpose of analyzing trends, injury prevention initiatives and WHSCC claims management. It will only be used for this purpose. This personal information is collected under the authority of the OCCUPATIONAL HEALTH AND SAFETY ACT (RSNL1990 CHAPTER O-3). All personal information will be stored in accordance with our normal network and information security measures. Personal information will not be disclosed unless required to do so by law. For further information about the collection and use of this information, please contact your supervisor.

Identifying Information

Part A to be completed in ALL cases (please indicate if employee or learner)

1) Surname:	2) Given Name	3) Position	4) Employee #
5) Campus/Department	6) Work Ph.	7) Date of Birth (YY/MM/DD)	8) Time/Date of Injury Y/MM/DD
9) Witness name(s) & Ph. #	10) Time & Date Reported (YY/MM/DD)	11) Supervisor Name & Ph. #	
12) Location of incident (site, building, room #, geographic, etc.)		13) Task/Activity employee was involved in at time of incident	
14) Is this a recurrence of a previous on-the-job injury or exposure? □ Yes □ No		If yes, give date of original injury/incident.	
15) Shift - Day, Evening, Night	16) Were WHSCC forms submitted? □ Yes □ No	17) Is physician note (Form 8/10) attached, where necessary? □ Yes □ No	

Description

18) Describe how the event occurred? (Short narrative)

Losses

19) **Loss to People**

□ Lost Time, □ Medical Aid, □ First Aid, □ Fatality, □ Occupational illness/disease, □ Reportable Occurrence, □ Near miss

20) **Loss to Environment/Materials/Equipment**

□ Property damage, □ Equipment damage, □ Loss of materials, □ Environmental damage, □ Near Miss, □ Other

Brief description of loss:

21) **Part of Body**

□ Eyes, □ Head/Face/Neck, □ Back, □ Trunk, □ Arm, □ Hand/Wrist, □ Finger, □ Leg, □ Foot/Ankle, □ Toe, □ Internal/Other

22) **Nature of Injury**

□ Amputation, □ Burn & Scald, □ Burn (chemical), □ Concussion, □ Cut, Laceration, Puncture, Abrasion, □ Fracture, □ Hernia, □ Bruise, Contusion, □ Occupational Illness, □ Musculoskeletal, sprain, strain, □ Other

23) **Type of Incident**

□ Fall from elevation, □ Fall on same level, □ Struck against, □ Struck by, □ Caught in, under, or between, □ Rubbed or abraded, □ Bodily reaction, □ Overexertion, □ Contact with electrical current, □ Contact with temperature extreme, □ Radiations, caustics, toxic, and noxious substances, □ Motor vehicle incident, □ Other, □ Unknown If other, describe:

24) **Source of injury** (Machine, tool, vehicle, building material, moving equipment, etc.)

Loss of Work

Part B to be completed only if the employee does not report to work for the next scheduled shift

25) Did employee engage in work immediately after the injury/incident? □ Yes, □ No, □ N/A Normal work: □, Other □ Describe below:

26) Period worked from **YY MM DD** To **YY MM DD**

27) Where is the employee now (home, hospital, work, etc.)

Sign Off

Part C to be completed in ALL cases and signed

29) Reported by	Signature	Date
30) Employee (if possible)	Signature	Date
31)) Supervisor	Signature	Date
32) Anticipated date of investigation, if not completed at this time	Date	