

ACCIDENT / INCIDENT INVESTIGATION REPORT

GUIDE TO COMPLETING THE ACCIDENT/INCIDENT INVESTIGATION REPORT FORM

Definition of Incident: An unplanned event that results in, or could result in, an injury or fatality, or damage/destruction of equipment, property or the environment.

Incidents may result in one or more of the following:

- **Near-Miss:** An incident that does not result in an injury
- **First-Aid:** Treatment such as ice packs, bandages or eyewash flushing, etc.
- **Medical Aid:** Treatment or examination by a physician, dentist, chiropractor, physiotherapist, emergency room attendant or similar health care practitioner.
- **Lost Time:** Unable to attend the next regularly scheduled shift of work

This form must be completed and sent to your supervisor or Brescia contact ASAP, so that it can be reviewed and forwarded to the proper authorities **WITHIN 72 HOURS** of the incident

Instructions for the Person Involved in the Incident:

- Check the appropriate box under the Incident Classification section
- Continue with relevant sections, as outlined below;
 - **Employees** complete sections **A, B, C, F, G, I**
 - **Students** complete Sections **A, B, D, F, G, I**
 - Attach Work/Education Placement Agreement if student is on placement
 - **Visitors and Contractors** complete Sections **A, B, E, F, G, I**
 - **Witnesses** complete section **J**
- If an incident later escalates into a medical aid or lost time, you must notify your Supervisor or Brescia contact of this change

Instructions for Supervisors and other Brescia Contacts:

- Review the completed form, as submitted by the person involved in the incident.
- Complete Sections H and I
- Attach any additional information relevant to this incident (witness statements, MSDS info sheets, etc.)

For Further Information:

- Contact: Jennifer Brennan, Compensation & Benefits Officer
1285 Western Road, Room 153
London, On, N6G 1H2
- Telephone (519) 432-8353 ext. 28053; Fax: (519) 858-5116; E-mail: jbrenn2@uwo.ca

EMPLOYEE RESPONSIBILITIES

1. Promptly receive first aid.
2. Notify your supervisor immediately of any injury, including injuries which do not require medical attention or lost time.
3. Choose a doctor or other qualified practitioner (hospital, physician, chiropractor, physiotherapist, registered nurse -extended class, dentist).
4. Complete and return all report forms received from the WSIB.
5. In the case of a lost time injury, keep your supervisor updated as to your progress.

SUPERVISOR RESPONSIBILITIES

1. Ensure that first aid is received.
2. Provide transportation for the employee to a medical facility or to their home.
3. Investigate the accident and determine causes and make necessary changes.
4. Send a completed accident report to the Payroll Office within 24 hours.

CRITICAL INJURY IS DEFINED AS AN INJURY OF A SERIOUS NATURE THAT:

- (a) Places a life in jeopardy.
- (b) Produces unconsciousness.
- (c) Results in substantial loss of blood.
- (d) Involves the fracture of a leg or arm but not a finger or toe.
- (e) Involves the amputation of a leg, arm, hand or foot, not a finger or toe.
- (f) Consists of burns to a major part of the body.
- (g) Causes the loss of sight in an eye.

IN THE EVENT OF A CRITICAL INJURY, SUPERVISORS ARE RESPONSIBLE FOR:

1. Arrange for immediate medical attention.
2. Notifying – UWO Campus Police at: 978-2222
 - Ministry of Labour (8:30 a.m. to 5:00 p.m.): 416-314-5421 or 1-800-991-7454
(Nights/Weekends/Holidays): 416-325-3000 or 1-800-268-6060
 - Representative from the Joint Health and Safety Committee.
 - Human Resources Ingrid Christensen 519-432-8353 ext. 28208
 - Worker Representation Adam Cake 519-432-8353 ext. 28267
- . Ensuring the site of the accident remains undisturbed until a Ministry of Labour inspector has arrived.
4. Preparing a written report of the circumstances of the accident.

ACCIDENT/INCIDENT INVESTIGATION REPORT

**Brescia University College
1285 Western Road
London, Ontario Canada N6G 1H2**

****RELEVANT SECTIONS MUST BE COMPLETED IN FULL BY EMPLOYEE'S SUPERVISOR**
SUBMIT WITHIN 24 HOURS TO: PAYROLL OFFICE OR FAX: 519-858-5116**

Person involved:	<input type="checkbox"/> Employee	<input type="checkbox"/> Student	<input type="checkbox"/> Contractor	<input type="checkbox"/> Visitor
Sections to complete:	A, B, C, F, G, I	A, B, D, F, G, I	A, B, E, F, G, I	A, B, E, F, G, I
Supervisor: Ensure all sections are completed, including H and I				

A. ACCIDENT / INCIDENT CLASSIFICATION

- | | |
|--|---|
| <input type="checkbox"/> First Aid (no medical treatment required) | <input type="checkbox"/> Near Miss (no injury) |
| <input type="checkbox"/> Medical Aid (medical treatment required) | <input type="checkbox"/> Hazardous Situation |
| <input type="checkbox"/> Lost Time (medical treatment required & absent) | <input type="checkbox"/> Recurrence, if previous injury (provide claim #
If possible)_____ |

B. PERSONAL INFORMATION OF PERSON INVOLVED

Full Name _____	<input type="checkbox"/> Male	<input type="checkbox"/> Female
S.I.N.: _____	Date of Birth (d/m/y) _____	
Address _____	Telephone (include area code) _____	
City _____	Province _____	Postal Code _____

C. EMPLOYEES TO COMPLETE THIS SECTION

Name of Supervisor _____	Department _____
Job Title _____	Length of Time in Position _____
Normal work days and hours _____	Hire Date(d/m/y) _____

D. STUDENTS TO COMPLETE THIS SECTION

Student Number _____	Campus Location _____
Was the incident program related? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Did the incident occur on placement? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, is this a paid placement <input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, name and phone # of placement employer _____	

E. CONTRACTORS and VISITORS TO COMPLETE THIS SECTION

<input type="checkbox"/> Contractor	<input type="checkbox"/> Visitor
College Contact _____	
Company Name and Address _____	
Reason for being at Brescia College University _____	

F. INCIDENT INFORMATION

Date of Incident (d/m/y) _____ Time _____ a.m./ p.m
 Date Reported (d/m/y) _____ Time _____ a.m./ p.m
 Reported to _____ Position _____ Telephone () _____
 Individual(s) witnessing or having knowledge of the incident _____

Location (campus/building/room/other) _____

Description of Incident (What happened? What was the task/activity? Were there any people, equipment or materials involved?)

Identify the size, weight and type) _____

Was the Incident/Illness: Sudden Specific Gradually Occurring Over Time

Type of Incident/Illness: (Please select ONE only)

- | | | | |
|--------------------------------------|--|--------------------------------|----------------|
| <input type="checkbox"/> Cut/ Scrape | <input type="checkbox"/> Overexertion | Needle stick/Puncture | Burn |
| <input type="checkbox"/> Slip/Trip | <input type="checkbox"/> Repetitive | Assault | Fire/Explosion |
| <input type="checkbox"/> Fall | <input type="checkbox"/> Struck/Caught | Harmful Substances/Environment | Motor Vehicle |

Area of Injury (Body Part) – Please check all that apply

- | | | | | | | | | | | |
|---------------------------------|--------------------------------|-------------------------------------|------------------------------------|--------------------------|----------------------------------|--------------------------|------------------------------------|--------------------------|---------------------------------|--------------------------|
| <input type="checkbox"/> Head | <input type="checkbox"/> Teeth | <input type="checkbox"/> Upper back | Left | Right | Left | Right | Left | Right | Left | Right |
| <input type="checkbox"/> Face | <input type="checkbox"/> Neck | <input type="checkbox"/> Lower Back | <input type="checkbox"/> Shoulder | <input type="checkbox"/> | <input type="checkbox"/> Wrist | <input type="checkbox"/> | <input type="checkbox"/> Hip | <input type="checkbox"/> | <input type="checkbox"/> Ankle | <input type="checkbox"/> |
| <input type="checkbox"/> Eye(s) | <input type="checkbox"/> Chest | <input type="checkbox"/> Abdomen | <input type="checkbox"/> Upper Arm | <input type="checkbox"/> | <input type="checkbox"/> Hand | <input type="checkbox"/> | <input type="checkbox"/> Thigh | <input type="checkbox"/> | <input type="checkbox"/> Foot | <input type="checkbox"/> |
| <input type="checkbox"/> Ear(s) | | Pelvis | <input type="checkbox"/> Elbow | <input type="checkbox"/> | <input type="checkbox"/> Fingers | <input type="checkbox"/> | <input type="checkbox"/> Knee | <input type="checkbox"/> | <input type="checkbox"/> Toe(s) | <input type="checkbox"/> |
| | | | <input type="checkbox"/> Forearm | <input type="checkbox"/> | | | <input type="checkbox"/> Lower Leg | <input type="checkbox"/> | | |
- Other _____

Have you had any prior similar problem? Please clarify. _____

G. FIRST AID, HEALTH CARE AND LOST TIME/NO LOST TIME

Describe first aid treatment, if applicable:

For medical aid and lost time, provide the following:

Name of attending doctor/facility _____
 Address _____
 Telephone (include area code) _____
 Date seen (d/m/y) _____

Provide the date the college learned of medical attention (d/m/y) _____

After the date of incident, **have you lost any time or earnings from your job/placement/classes?** Yes No

Start date of lost time (d/m/y) _____ Date of return (d/m/y) _____ Returned to Regular Modified

Has an Absence Report been forwarded to HR identifying WSIB Lost Time? Yes No

H. SUPERVISOR'S INCIDENT FOLLOW-UP AND ACTION PLAN

What were the causes of the incident? (Consider contributing factors, conditions, unsafe acts, personal/job factors.)

Was personal protective equipment used at the time? Please clarify _____

Was Property damaged (vehicle/equipment/materials)? Please clarify _____

Supervisor Action Plan (Describe action to be taken to prevent recurrence, and any recommendations)

Action Plan (include what and why recommendations are made)	Party Responsible	Completed Date	Follow Up

Supervisor Responsible _____ Date (d/m/y) _____

I. SIGNATURES – E-mail completed document, within 24 hours of the incident, to:

1) Jennifer Brennan (jbrenn2@uwo.ca) 2) Supervisor 3) Person Involved

Person Involved (print clearly) _____ Department _____

Signature _____ Date (d/m/y) _____

Supervisor or Brescia Contact (print clearly) _____ Department _____

Signature _____ Date (d/m/y) _____

FOR OFFICE USE ONLY:

Reviewed by H&S (print clearly) _____ Date (d/m/y) _____

Signature _____

