Ontario Safety Association for Community & Healthcare

Employee Incident Report

Employee Information

Last Name |__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|

First Name |__|__|__|__|__|__|__|__|__|__|__|__| Date of Birth (DD/MM/YY) |__|__|/|__|__|/|__|__|

Home Telephone No. |__|__|__| -|__|__|__|__|(|__|__|__|)

Work Telephone No. |__|__|__| -|__|__|__|__|(|__|__|__|)

Employee ID#______________ / SIN |__|__|__|-|__|__|__|-|__|__|__|

Address ____________________ City/Town ____________ Province ________ Postal Code |__|__|__||__|__|__|

Division/Dept./Unit ____________________

Occupation at time of Injury ____________________

Check: ☐Full-time ☐Casual ☐Part-time ☐Student

|__|__| Years of Experience

Was the employee on the job when the injury occurred? (check) ☐ YES ☐ NO

Description of Incident

Date of Incident (DD/MM/YY) |__|__|/|__|__|/|__|__|

Time of day __________ AM/PM

Date Reported (DD/MM/YY) |__|__|/|__|__|/|__|__|

Time of day __________ AM/PM

To whom was the incident reported? ____________________

If report is delayed, please explain why.

State the exact sequence of events leading up to the incident. Include an explanation of what the employee was doing.

Did the accident happen on the employer's premises?

What caused the injury/illness?

Identify the sizes, weights & types of equipment involved.

Type of Incident (check one—definitions on reverse):

1 ☐ Struck/Caught
2 ☐ Overexertion
3 ☐ Repetition
4 ☐ Fire/Explosion
5 ☐ Fall
6 ☐ Harmful Substances/Environmental
7 ☐ Assault
8 ☐ Other
9 ☐ Slip/Trip
10 ☐ Motor Vehicle Accident

Witnesses

Names, positions, & phone numbers of witnesses or persons having knowledge of the incident.

Cause

Was the accident/illness:

1☐A Sudden, Specific Event/Occurrence? 2☐Gradually Occurring Over Time? 3☐An Occupational Disease? 4☐A Fatality?

Direct causes (check one – see reverse): 1☐Physical/Environmental 2☐Personal

Basic causes (check one): 1☐Job factors 2☐Personal factors

Correction

Action(s) Taken	CORRECTED (check box)	PLANNED (check box)	Date (DD/MM/YY)
1 ______	☐	☐	|__|__|/|__|__|/|__|__|
2 ______	☐	☐	|__|__|/|__|__|/|__|__|
3 ______	☐	☐	|__|__|/|__|__|/|__|__|
4 ______	☐	☐	|__|__|/|__|__|/|__|__|
5 ______	☐	☐	|__|__|/|__|__|/|__|__|
6 ______	☐	☐	|__|__|/|__|__|/|__|__|
7 ______	☐	☐	|__|__|/|__|__|/|__|__|

Examples of Actions:
1. Reinstruction of person involved
2. Reassignment of person
3. Order job safety analysis done
4. Improve personal protective equipment
5. Action to improve inspection
6. Equipment repair or replacement
7. Correction of congested area
8. Installation of guard or safety device
9. Actions to improve design/procedure
10. Check with manufacturer
11. Inform all department supervisors
12. Discipline of persons involved
13. Other:

Injury

Describe the illness or injury, part of body involved and specify left or right side.

Are you aware of any prior similar or related problem, injury, or condition? If yes, please explain:

No injury (check one)
1☐Hazardous situation

Injury – No WSIB Claim (check one)
1☐First aid
2☐No aid

WSIB Claim Treatment Memorandum (check one)
1☐Health care (medical aid)
2☐Lost time

Occupational Health

Did employee seek medical attention? (check one) 1☐No 2☐Yes
Did employee visit health service? (check one) 1☐No 2☐Yes
Did employee visit emergency? (check one) 1☐No 2☐Yes
If Yes, ER Physician's Name ____________________
Tel.No. (|__|__|__|) |__|__|__| -|__|__|__|__|

Did employee visit family physician? (check one) 1☐No 2☐Yes
If Yes, Physician's Name ____________________
Tel.No. (|__|__|__|) |__|__|__| -|__|__|__|__|
Physician's Address ____________________

Will the employee undertake: (check one)
1☐Regular duties
2☐Modified duties
3☐Remain off work

Has the employee had a similar disability? (check one)
1☐Yes
2☐No
3☐Unknown

Check attachments to this report.
1☐Statements
2☐Photographs
3☐Treatment memo
4☐Other – specify: ____________

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EMPLOYEE SIGNATURE Date | MANAGER SIGNATURE Date | OCC. HEALTH DEPT. SIGNATURE Date

This Information is to be used for completion of WSIB Claim Form 7

Instructions for Completion
Employee Incident Report

ORIGINAL to be kept in "Employee Incident Report" file in H&S area/division

2ND COPY to injured worker's supervisor

3RD COPY to injured worker's occupational health or employee file

The purpose of this report is to:

- Collect factual data relating to the occurrence of a workplace injury
- Collect data for completion of the WSIB report
- Provide a systematic means to record incidents, document the results of investigations and note how, when and what corrective action will be taken
- Help to ensure the provision of prompt medical treatment
- Assist in the determination of the causative factors related to the incident
- Systematically collect factual data for statistical records
- Guide the investigator in conducting an effective investigation

NOTE: Shaded information is considered confidential and should not be shared with the joint health and safety committee.

Types of Incidents - Definitions

Struck/Caught

- An incident in which a person has been struck abruptly or forcefully by some object in motion (e.g., box falls off shelf, employee jabs needle into finger, person pushing cart runs into someone) or a person is contacted non-forcefully by some substance or agent in motion that has an injury-upon-contact characteristic (such as being splashed by hot or corrosive solutions).
- An incident in which a person strikes abruptly or forcefully some stationary object in his/her surroundings (e.g., nurse strikes his/her leg against the crank of a bed) or comes into contact, non-forcefully, with some stationary substance or agent that has an injury-upon-contact characteristic (such as electrical shock).
- An incident in which a person is:

a. trapped in some type of enclosure or a part of a person's body is caught in some type of opening (e.g., a person is caught in an elevator or locked into a refrigerated room)
b. caught on some protruding object (e.g., a person's clothing gets hooked onto a handle or a person catches his/her hand on a sharp edge)
c. pinched, crushed or otherwise caught between either a moving object and a stationary object or between two or more moving objectives (e.g., a person jams his/her fingers between a wheeled cart and doorway).

Fall

A fall on the same level on which a person was standing or walking, or when a person falls to below the level on which he/she was standing or walking.

Slip/Trip

The person either slips or trips but does not fall.

Overexertion

An incident is one in which a person puts excessive strain on some part of his/her body (e.g., an employee strains his/her back or some other part of the body).

Harmful Substances/Environmental

An incident in which the employee is exposed to harmful condi¬tions (e.g., toxic gases, fumes or vapours; toxic airborne particles; extremes of heat or cold; oxygen deficient atmospheres; radioac¬tive radiation; intense light brightnesses, infectious diseases, blood/blood-stained body fluids, moulds/spores).

Assault

An incident in which the employee is subjected to an untoward action by a patient or member of the public (e.g., a patient bites or strikes an employee).

Repetition

An incident that develops over a period of time due to the repetitive nature of the task being carried out (e.g., pipetting, keyboarding).

Fire/Explosion

An incident in which the employee is subjected to a fire or explosion in the workplace.

Motor Vehicle Accidents

An incident in which the employee is involved in a motor vehicle accident during the course of his/her work activities.

Direct Causes - Definitions

Physical/Environmental

Contributing conditions such as machinery/equipment, house¬keeping, physical agents, chemical agents, personal protective equipment, temperature (heat/cold), etc.

Personal

Contributing actions such as unauthorized equipment use, improper body motion, working at unsafe speeds.

Basic Causes - Definitions

Job Factors

Work procedures, purchasing, design, training, engineering controls, etc.

Personal Factors

Physical restrictions, lack of training, motivation, inadequate capability, etc.