GROUP HEALTH CENTRE

EMPLOYEE INCIDENT REPORT

PART ONE – EMPLOYEE'S REPORT

EMPLOYEE TO COMPLETE

Employee complete Part 1 and sign the bottom of the form. Submit the form to your Manager/Supervisor immediately after your incident. If you seek **HEALTH CARE OR experience LOST TIME**, speak directly to your Manager or their delegate who will make every attempt to offer suitable modified work.

Last Name : _____ First Name: _____ Date of Birth: _____

Address: _____ Postal Code: _____ SIN# _____

Occupation: _____ ☐ Full Time ☐ Part Time ☐ Casual Years of Experience: _____

Date of incident: _____ Time of Day: _____ Home Phone: _____

Date incident reported: _____ Time of Day: _____ Work Extension: _____

Location of incident: _____ Department: _____

Manager's Name: _____ Who reported to: _____

Description of Incident (Explain how incident occurred, equipment used including sizes, weight, etc.)

Describe Injury and All Parts of the Body Involved (specify Left or Right)

Type of Incident

☐ Struck or contacted by ☐ Caught in/on/between ☐ Struck against ☐ Slip/trip/fall ☐ Overexertion/Strain
☐ Repetitive Action ☐ Violence/Harassment ☐ Exposure ☐ Patient Action ☐ Other:_____

Nature of Injury

☐ Abrasion ☐ Laceration ☐ Fracture ☐ Contusion/Bruising ☐ Strain/Pull ☐ Strain/Twist
☐ Burn ☐ Amputation ☐ Cardiac Arrest ☐ Respiratory ☐ Crushing ☐ Seizure
☐ Loss of Consciousness ☐ Hearing Loss/Impairment ☐ Other: _____

Reminder: If you plan to seek medical attention related to this incident, please update Human Resources at ext. 5581 with the name of the Health Care Provider you are seeing and your appointment date.

NAME OF WITNESSES TO OR PERSONS HAVING KNOWLEDGE OF INCIDENT : _____

EMPLOYEE SIGNATURE: _____

This form faxed to Human Resources by : _____ _____
Name **Date**

GROUP HEALTH CENTRE

EMPLOYEE INCIDENT REPORT

MANAGER/SUPERVISOR TO COMPLETE

PART TWO – MANAGER/SUPERVISOR'S INVESTIGATION (FOLLOW UP) REPORT

Manager/Supervisor completes Part 2 (within 48 hours) once the employee has completed Part 1 and ensures both forms are faxed to Human Resources **759-5565** immediately as WSIB information must be sent within 3 days.

☐ NO INJURY ☐ FIRST AID ☐ HEALTH CARE ☐ LOST TIME ☐ CRITICAL INJURY

LAST NAME	FIRST NAME
DEPARTMENT	MANAGER
DATE OF INCIDENT / DATE REPORTED	LOCATION WHERE INJURY OCCURRED

WHAT CONDITION(S) CONTRIBUTED TO THE INCIDENT

☐ PEOPLE ☐ EQUIPMENT ☐ MATERIALS ☐ PROCESS ☐ ENVIRONMENT

DETAILS: _____

_____

INVESTIGATION – INCLUDE ALL CONDITIONS THAT CONTRIBUTED TO THE INCIDENT

Who?

What?

Where?

How?

Why?

ACTIONS TO PREVENT INCIDENT RECURRENCE

MARK WITH (✓) THOSE ACTIONS TAKEN TO PREVENT RECURRENCE. MARK WITH (P) OTHER CORRECTIVE ACTIONS DECIDED UPON OR PLANNED BUT NOT YET CARRIED OUT. MORE THAN ONE ITEM MAY APPLY.

- ☐ IMPROVED PERSONAL PROTECTIVE EQUIPMENT
- ☐ REINSTRUCTION OF PERSON INVOLVED
- ☐ REASSIGNMENT OF PERSON
- ☐ ORDER JOB SAFETY ANALYSIS DONE
- ☐ ACTION TO IMPROVE INSPECTION
- ☐ EQUIPMENT REPAIR OR REPLACEMENT
- ☐ CORRECTION OF CONGESTED AREA
- ☐ ACTIONS TO IMPROVE DESIGN/PROCEDURE
- ☐ CHECK WITH MANUFACTURER
- ☐ INFORM ALL DEPARTMENT SUPERVISION
- ☐ DISCIPLINE OF PERSONS INVOLVED
- ☐ INSTALLATION OF GUARD OR SAFETY DEVICE
- ☐ OTHER (EXPLAIN) _____

DETAILS OF ACTIONS TAKEN TO PREVENT RECURRENCE

1.

2.

3.

4.

SIGNATURE OF MANAGER/SUPERVISOR WHO COMPLETED INVESTIGATION	EMPLOYEE SIGNATURE:

HUMAN RESOURCES

Has employee had similar disability ☐ Yes ☐ No Physician's Name: _____

Did employee visit Occupational Health & Safety Centre ☐ Yes ☐ No Chiropractor/Physio: _____

Did employee visit Emergency Department at SAH ☐ Yes ☐ No Same Day Appointment Clinic at GHC ☐ Yes ☐ No

Employee will: ☐ Resume Regular Duty ☐ Modified Duty ☐ Remain off Work

Signature: _____ Date: _____