McGill ACCIDENT, INCIDENT & OCCUPATIONAL DISEASE REPORT FORM

INJURED PARTY/COMPLAINANT TO COMPLETE Sections A & B, **SIGN, DATE & SUBMIT** to your immediate supervisor/department within 24 HOURS of the event.

Section A: General Information (Injured Party/Complainant)	
Last Name	First Name
Faculty/Staff ☐ Student ☐ Visitor ☐	McGill ID Number
Department	Position
Daytime Phone Number	Evening Phone Number

Section B: Description of the Event		
When	Date of Event (MM/DD/YYYY)	Time of Event
	Date Reported	Time Reported
Where	Location of Event (Laboratory, office, stairs, etc.)	Building
		Floor & Room
What happened? (Description of the event and how it occurred)		
Were you injured? (Description of injury, including parts of the body)		
What factors contributed to the event?		
How could the event have been avoided?		
Was First aid administered? YES ☐ NO ☐		If yes, by whom?
Signature of Injured Party/Complainant		Date

If form completed by someone other than the injured party, please fill out the following lines:

Form Completed by:	Telephone Number
Signature	Date

Environmental Health & Safety
3610 McTavish Street, 4th Floor, Montreal (Quebec) H3A 1Y2 CANADA
Telephone 514.398.4563 Fax 514.398.8047 ehs@mcgill.ca www.mcgill.ca/ehs
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IMMEDIATE SUPERVISOR TO COMPLETE Sections C & D, **SIGN, DATE & SEND** to Environmental Health & Safety within 24 HOURS. **IF injury occurred, SEND** copy to Benefits Office (688 Sherbrooke Street West, 14th Floor - Fax 514.398.6889).

Section C: General Information

Supervisor's Last Name	Supervisor's First Name
Department	Position
Phone Number	Email
If there was a delay in reporting this event, list reason(s):	
Material Damage YES ☐ NO ☐	Approximate Value:

Section D: Preventative Measures

Cause of event – Root Causes (e.g., unsafe equipment, lack of training, etc.)

What corrective actions are being taken to prevent recurrence?

Have person(s) involved received training or instruction in the work or activity being carried out? YES ☐ NO ☐

Was there any supervision of the work or activity being carried out? YES ☐ NO ☐

Supervisor's Comments (Additional information on event)

If injury occurred, please check one:

- ☐ No First-Aid administered, returned to work
- ☐ First-Aid administered, returned to work
- ☐ Saw a physician, returned to work
- ☐ Saw a physician, returned to light duty
- ☐ Saw a physician, time loss
- ☐ Refused medical treatment

Supervisor's Signature Date

EH&S Office Use Only

Reviewed by			**Date**	
Distribution:	☐ Risk Management	☐ Benefits Office, HR	☐ Dept. Chair/Head	☐ Dean of Students
Follow-Up:	☐ Supervisor ☐ Dept. Chair/Head	☐ Building Director ☐ Dept. Safety Com.	☐ Facilities Management ☐ Other _____	☐ Waste Management ☐ Other _____