|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Worker** | | | | | | | |
| Name | | | Phone # | | | | |
| Job Title and Department | | | Did you complete the shift?  yes  no | | | | |
| Hours Worked | | | Hours Scheduled | | | | |
| **Incident** | | | | | | | |
| Reported by (Name and Title): | | Reported to (Name and Title): | | | | Date Reported (dd/mm/yyyy):\_\_\_\_/\_\_\_\_/\_\_\_\_  Time Reported:  a.m.  p.m. | |
| Date of Occurrence (dd/mm/yyyy):\_\_\_/\_\_\_/\_\_\_  Time of Occurrence:  a.m.  p.m. | | Exact Location of Incident: | | | | If there was a delay in reporting, explain: | |
| **Incident Type** | | | | | | | |
| Property Damage  Exposure  Report Only (hazard observed)  Near Miss (incident with no injury)  First Aid only  Medical Treatment (external)  Emergency Treatment  Where: Where: | | | | | | | |
| **Nature of Injury / Illness** | | **Body Part - Right / Left** | | | | **Incident Type** | |
| Allergy  Amputation  Bruise/contusion  Burn □ chemical □ electrical □ heat  Crush injury  Cut/puncture/abrasion  Exposure  Fracture  Head injury  Illness - work related  Psychological  Respiratory  Skin Condition  Sprain/strain  Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | Arm  Ear  Eye  Finger  Foot/ankle  Hand/wrist   Leg  Shoulder  Toe  Abdomen  Back  Chest  Face  Head/neck  Internal  Other \_\_\_\_\_\_\_\_\_\_\_ | | R | L | Assault / Bite / Hit   * Bodily fluid exposure/splash * Bending climbing, crawling, reaching twisting   Caught in/under/between  Contact electrical current  Contact extreme temperature  Contact hazardous substance  Fall from elevation  Fall on same level  Motor vehicle accident (MVA)  Needle Stick  Overexertion  Repetitive movement   * Rubbed or abraded * Slip or trip without fall * Struck against/by   Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |
| R | L |
| R | L |
| R | L |
| R | L |
| R | L |
| R | L |
| R | L |
| R | L |
|  |  |
| **Describe what happened. Report any details that may have contributed to the incident (e.g. ice on ground)** | | | | | | | |
| (Use other side of form if needed) | | | | | | | |
| **Describe the outcome** | | | | | | | |
| Injury/health effects/damage:  Was first aid provided?  yes  no  n/a If yes, by whom? | | | | | | | |
| **Witness(es)** | | | | | | | |
| Name and contact information: | | | Name and contact information: | | | | |
| **To be Completed by Supervisor** | | | | | | | |
| Where did the worker go next?  Healthcare  Home  Work  Other | | | | | | | |
| Was the worker advised to return the FAF after their medical appointment?  Yes  No | | | | | | | |
| Date modified or alternate duties were offered to begin: | | | | | | | |
|  | **Name (Print)** | | | **Signature** | | | **Date** |
| Worker: |  | | |  | | |  |
| Supervisor/Manager: |  | | |  | | |  |
| Return to Work Coordinator: |  | | |  | | |  |

|  |
| --- |
| **Corrective actions (to be completed by the supervisor with worker input) - What can be done to prevent or eliminate the hazard and incident from occurring again?** |
|  |
|  |
|  |
|  |
|  |
|  |
|  |
|  |
|  |
|  |
|  |
|  |
|  |
|  |
| **Additional comments or circumstances relevant to this incident:** |
|  |
|  |
|  |
|  |
|  |
|  |
|  |
|  |
|  |
|  |
|  |
|  |