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| **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 |
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| **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: |  |  |  |

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| **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?** |
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| **Additional comments or circumstances relevant to this incident:** |
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