ILLNESS or INJURY INCIDENT REPORT

This form must be initiated and faxed/ emailed within 24 hours of the Supervisor learning of the incident. Fax to 519-780-1796 or ohw@uoguelph.ca Submit additional information as available.

<table>
<thead>
<tr>
<th>Injurious Incident?</th>
<th>Injury</th>
<th>1st Aid</th>
<th>No 1st Aid</th>
<th>Health Care (Medical Aid)</th>
</tr>
</thead>
</table>

Who was the affected person?

- EMPLOYEE
- STUDENT
- VISITOR
- VOLUNTEER
- CONTRACTOR

<table>
<thead>
<tr>
<th>Last Name:</th>
<th>First Name:</th>
<th>Initial:</th>
<th>Phone or Extension:</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Occupation, if applicable:</th>
<th>Department:</th>
<th>Union/Bargaining Group:</th>
</tr>
</thead>
</table>

Name of Supervisor:

<table>
<thead>
<tr>
<th>Phone or Extension:</th>
<th>Name of Dept. Head:</th>
</tr>
</thead>
</table>

Date & Time of Incident:

<table>
<thead>
<tr>
<th>Date Reported to Supervisor:</th>
<th>Date Submitted:</th>
</tr>
</thead>
</table>

If Slip or Fall describe footwear:

- Slip, Trip or Fall
- Electrical Shock/Burn
- Needle/Sharps/Puncture/Cut
- Loss of Consciousness

If yes, Name, Address and Phone Number of Medical Professional:

- If yes, Date of Visit:

- If yes, Name, Address and Phone Number of Medical Professional:

If yes, Date of Visit:

- If yes, Name, Address and Phone Number of Medical Professional:

Description of Incident:

Witnesses (Name/Phone Number):

Where did the incident occur?

- Guelph Campus
- Kemptville Campus
- Ridgetown Campus
- Research Station:
- Other

Building Name:

<table>
<thead>
<tr>
<th>Room Number:</th>
</tr>
</thead>
</table>

What was the injury:

Select part of body and indicate Right (R) Left (L), both (B) or Quantity Injured in the box:

- Head
- Teeth
- Pelvis
- Elbow
- Upper Back
- Knee
- Toes
- Face
- Neck
- Shoulder
- Wrist
- Lower Back
- Lower Leg
- Eye
- Abdomen
- Upper Arm
- Hand
- Hip
- Ankle
- Ear
- Chest
- Lower Arm
- Fingers
- Upper Leg
- Foot

Did you see a medical professional?

- No
- Yes If yes, Date of Visit:

Treatment of injury:

- Occ Health / Dept. First Aid
- Physician /Clinic
- No First Aid Req’d
- Emergency Room
- Student Health Services

Continued on Page 2

Revised July 2018

Incident Report Page 1
Contributing Factors: What conditions contributed to the incident?
- Operating W/O Authority
- Inadequate Housekeeping
- Inadequate Work Procedure
- Improper Position/Posture
- Failure to Lockout
- Inadequate Illumination
- Insufficient Training
- Infraction OR Unsafe Practice
- Unsafe Equipment
- Failure of Personal Protective Equipment
- Not or Improperly Guarded
- Hazardous Environmental Condition
- Inclement Weather
- Other

Explanation of Contributing Factors:

Details of Property Damage (if any):

To your knowledge, has the employee reported a previous similar injury or similar hazardous situation before?
- No
- Yes

Corrective Measures: Actions taken to prevent a reoccurrence (Check all that apply):
- Control Operation / Access
- Perform Housekeeping
- Review Personal Protective Equipment
- Improve Work Procedure
- Ergonomic Assessment
- Install Safety Guard / Device
- Apply Lockout / Tag-out
- Job Safety Analysis
- Inform Dept. Supervision
- Provide Training
- Request Lighting Review
- Inform all Staff
- Repair / Replace Equipment
- Reinstruction of Persons Involved
- Other

Explanation of Corrective Measures:

Deadline to complete Corrective Measure:

By Whom:

Date Completed:

Signature of Person Reporting Incident

Supervisor Signature

Dept. Head Signature

Reminder: For Health Care (Medical Aid) Injuries ensure the Injury Package is given to the employee.

Indicate / ensure copies are distributed to: ☐ Dept. Head ☐ Union / Bargaining Group ☐ Local JHSC as appropriate

Description of Incident continued:

☐ Continued on Attachment
Purpose of the Incident Report Form

• To ensure compliance with Workplace Safety and Insurance Board and Occupational Health and Safety Act, which require timely reporting of occupational injury or disease.
• Information requested on this form will be used by Occupational Health and Wellness (OHW) for the completion of the required WSIB Form 7 and by the Environmental Health and Safety (EHS) to provide information to the Ministry of Labour, if required.
• The form also ensures the area supervisor is aware of, and has followed-up on, the incident/injury and/or property damage that has occurred.

Separate and confidential forms are available for submitting details of violence and harassment. This form need only be completed with minimum details: name of affected party, supervisor, location etc.

How to Fill Out this Form - The form has been divided into two sections. The top section is to be filled out by or for the injured person or the person involved in a hazardous situation. Students, visitors, and volunteers may require assistance. If the injured party is unable to fill out this section, for whatever reason, it is to be completed by the area or staff member’s supervisor or can be initiated by a co-worker if the supervisor is unavailable. The lower section is to be completed by the direct supervisor of the employee or of the area generating the report.

Injured Party Section

• Ensure that all personal information is entered correctly and the details of the incident are documented as thoroughly as possible. Every item in this section requires an answer. Please ensure the supervisory contact information is complete.
• If you require the use of an attachment, please indicate this by checking the “continued on Attachment” on the bottom of page 2.
• The form is to be signed by the injured party/worker (if they are able) or by the person reporting the incident, prior to faxing by the supervisor.

If you seek medical attention after the incident report form has been submitted, please notify your supervisor and OHW. Your supervisor will provide you with an Injury Package which includes a letter that explains the process, a Functional Abilities Form (FAF), and a letter to your health care practitioner about our modified work program.

Supervisor Section

• Contributing Factors: Check off one or more of the boxes that represent the causal factors of the incident being reported.
• For insurance reasons and/or to implement prevention strategies, ensure that any property damage is detailed in this section.
• Corrective Measures: Care must be taken to complete this important section. Indicate what steps were taken by the supervisor/employer to mitigate the risk(s) associated with the task and/or prevent its reoccurrence. For whatever action was taken or recommended, ensure that the details of the maintenance request/work order are outlined here. Also include the name of outside providers, where appropriate. Document known facts only.
• Acquire signatures before submitting form, if possible, however, do not delay submitting the form if you cannot obtain the signature of the injured party or the department head. This can be arranged later. Send the form into OHW so that the respective WSIB and MOL notifications can be made.
• Ensure that the department head, respective union/bargaining group and Local JHSC, as applicable receive a copy of this form. Indicate the distribution on this form.
• When an employee notifies you that he/she will be seeing a medical professional related to this recent incident, provide them with an Injury Package which includes a letter explaining the process, a Functional Abilities Form (FAF), and a letter for the health care practitioner.
• The Injury Package can be found on the OHW website
• Advise the employee that modified work is available and to return the completed FAF to OHW as soon as possible.

Note: For reporting workplace harassment or workplace violence, please use the the Workplace Harassment Reporting Form or the Workplace Violence Reporting Form.