

## Accident/Incident Report Form

To be completed by the immediate supervisor and forwarded to the Department of Health & Safety, immediately following notification of the accident/incident. Answer all questions, or signify if not applicable with N/A. Please complete both sides.

PART I – To be completed in ALL cases																			
Employee - Surname	Given Names	1. Time of Injury:	<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 15%; text-align: center;">hour   min</td> <td style="width: 10%; text-align: center;">am</td> <td style="width: 15%;"></td> <td style="width: 10%;"></td> </tr> <tr> <td></td> <td style="text-align: center;">pm</td> <td style="text-align: center;">yy   mm   dd</td> <td></td> </tr> </table>	hour   min	am				pm	yy   mm   dd									
hour   min	am																		
	pm	yy   mm   dd																	
Position	Employee Number	2. Time Reported to Employer:	<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 15%; text-align: center;">hour   min</td> <td style="width: 10%; text-align: center;">am</td> <td style="width: 15%;"></td> <td style="width: 10%;"></td> </tr> <tr> <td></td> <td style="text-align: center;">pm</td> <td style="text-align: center;">yy   mm   dd</td> <td></td> </tr> </table>	hour   min	am				pm	yy   mm   dd									
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Department	Work Phone	3. If not reported promptly, explain why:																	
Supervisors Name & Position	4. To Whom was Report Made?	Name																	
		Position																	
	5. Exact Location of the Incident:																		
6. What specific act was worker performing when incident occurred?																			
7. What specific equipment and/or materials was being used at the time of the incident?																			
8. What unexpected event occurred to cause the incident?																			
9. Part of Body Injured (Indicate Whether Left or Right Side):																			
10. Estimation of Nature of Injury (Check one or more):	<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 25%;">Amputation</td> <td style="width: 25%;">Bruise or Contusion</td> <td style="width: 25%;">Cut</td> <td style="width: 25%;">Hernia</td> </tr> <tr> <td>Burn or Scald (thermal)</td> <td>Concussion</td> <td>Laceration or Abrasion</td> <td>Illness</td> </tr> <tr> <td>Burn (chemical)</td> <td>Crushing Injury</td> <td>Bone Fracture</td> <td>Sprain or Strain</td> </tr> <tr> <td colspan="4">Other (specify)</td> </tr> </table>	Amputation	Bruise or Contusion	Cut	Hernia	Burn or Scald (thermal)	Concussion	Laceration or Abrasion	Illness	Burn (chemical)	Crushing Injury	Bone Fracture	Sprain or Strain	Other (specify)					
Amputation	Bruise or Contusion	Cut	Hernia																
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Other (specify)																			
11. Was first aid administered?	By whom?																		
12. Was medical treatment administered?	If yes, indicate hospital and doctor:																		
13. List any witnesses to the incident:																			
14. Was there any other person, directly or indirectly, responsible or involved?		Explain:																	
15. Was this injury related to a previous on-the-job injury?		Approximate date of previous injury:																	
PART 2—Please complete this section ONLY if worker has been absent from work as a result of this incident for longer than the day of injury.																			
16. Time employee was first disabled from work:	<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 15%; text-align: center;">hour   min</td> <td style="width: 10%; text-align: center;">am</td> <td style="width: 15%;"></td> <td style="width: 10%;"></td> </tr> <tr> <td></td> <td style="text-align: center;">pm</td> <td style="text-align: center;">yy   mm   dd</td> <td></td> </tr> </table>	hour   min	am				pm	yy   mm   dd		If employee has returned to work, give time he/she did so:	<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 15%; text-align: center;">hour   min</td> <td style="width: 10%; text-align: center;">am</td> <td style="width: 15%;"></td> <td style="width: 10%;"></td> </tr> <tr> <td></td> <td style="text-align: center;">pm</td> <td style="text-align: center;">yy   mm   dd</td> <td></td> </tr> </table>	hour   min	am				pm	yy   mm   dd	
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17. If not returned to work, how long should injury disable employee?		18. Where is employee now? (Home, Hospital, etc)																	
19. Did worker work at all after being first disabled?		20. Period Worked																	
		From	To																
		yy   mm   dd	yy   mm   dd																
21. Was it his/her normal work?		If no, describe:																	
PART 3 – SIGNED – To be completed in ALL cases																			
IMMEDIATE SUPERVISOR:		DATE:																	
INJURED PARTY:		DATE:																	

**PART 4 – Supervisor’s Investigation Report –To be completed in ALL cases**

22. Explain how any of the following may have contributed to this accident/incident:

A. Worker (attitude, physical condition, mental alertness, etc.)

B. Method of Procedure (training, familiarity, planning, etc.)

C. Conduct (wilful misconduct by worker or other)

D. Equipment and Material (condition, proper application, etc.)

E. Surroundings (confinement, housekeeping, environmental)

23 A. What applicable protective equipment was being used?

23 B. What should or could be used? Please specify.

24 A. Did you personally visit the scene of this accident/incident?

If yes, indicate date and time:

24 B. Was affected worker present?

25. Any comments or concerns on accident site:

26 A. Corrective action taken or planned to prevent a recurrence of this type of accident/incident:

26 B. Do you feel that anything should be done in addition?

If yes, please explain:

27. In your opinion is there any misrepresentation or concealment in this case?

28. Have you reviewed this accident/incident with other workers engaged in similar work?

**PART 5 – Signatures and Comments – To be completed in ALL cases**

Immediate Supervisor:

Date:

Comments:

Department Head or Representative:

Date:

Comments:

**PART 6 – Department of Health & Safety**

Reviewed By:

Date:

Entered on Database:

Follow-up investigation required:

Recommendation:

**PART 7 – Safety Committee Review and Comments**

## Detailed Incident Description

In the space provided, please describe in detail the incident.

Please answer (Who? What? Where? When? Why? How?) Be specific.

**(PLEASE PRINT CLEARLY)**

Injured Party's Signature: \_\_\_\_\_

Supervisor's Signature: \_\_\_\_\_

**(Please Print)**

Injured Party: \_\_\_\_\_

**(Please Print)**

Supervisor's Name \_\_\_\_\_

Please return completed form to: The Department of Health & Safety  
208 Elizabeth Avenue  
Memorial University