

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:		hour min		am	yy mm dd			
							hour min		pm				
Position		Employee Number			2. Time Reported to Employer:		hour min		am	yy mm dd			
							hour min		pm				
Department		Work Phone			3. If not reported promptly, explain why:								
Supervisors Name & Position		4. To Whom was Report Made?			5. Exact Location of the Incident:		Name						
							Position						
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):		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)											
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:		hour min		am	yy mm dd		If employee has returned to work, give time he/she did so:		hour min		am	yy mm dd	
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		yy mm dd		To		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