

# OCCUPATIONAL ILLNESS INVESTIGATIVE REPORT (R-4)



IF THIS CAN BE ISOLATED TO A SPECIFIC EVENT & TIME OF OCCURRENCE USE ACCIDENT/INCIDENT INVESTIGATIVE REPORTS (R-26) & FIRST AID REPORT (R-25). INVESTIGATIONS MUST BEGIN WITHIN 24 HOURS

WHO IS WRITING THIS REPORT		PRINT	
DATE		SIGN	
ARE THERE PHOTOS OR OTHER REPORTS ? IF SO PLEASE CIRCLE YES OR NO		YES	NO
DATE & TIME FIRST EXPERIENCED SYMPTOMS		DATE & TIME REPORTED	
LOCATION			
		DEPARTMENT	
ALBERTA			
REPORTED TO...			
NAME		DEPARTMENT	
TITLE			
SUPERVISOR (Name & Contact phone)			
SYMPTOMS			
1		3	
2		4	
HAS THE WORKER HAD THESE SYMPTOMS BEFORE?		IF YES, WHEN?	
OCCUPATIONAL ILLNESS TYPE (BY CAUSE)			
1. BY CHEMICAL AGENTS		SUSPECT CHEMICAL(S)	CHECK IF CONFIRMED
<input type="checkbox"/>	RESPIRATORY		
<input type="checkbox"/>	SKIN		
<input type="checkbox"/>	MALIGNANT		
<input type="checkbox"/>	OTHER		
2. BY PHYSICAL AGENTS		WHAT WAS THE WORKER DOING?	
<input type="checkbox"/>	UPPER LIMB REPETITIVE MOTIONS		
<input type="checkbox"/>	LOWER LIMB REPETITIVE MOTIONS		
<input type="checkbox"/>	BACK & NECK PROBLEMS		
<input type="checkbox"/>	HEARING LOSS		
<input type="checkbox"/>	OTHER		
3. BY BIOLOGICAL AGENTS		SUSPECT AGENT(S)	CHECK IF CONFIRMED
4. OTHER AGENT		COMMENTS	
EXPOSURE OR ACTIVITY OUTSIDE OF WORK SITE THAT MAY BE A FACTOR			
AFFECTED WORKER			
NAME		PHONE	HIRE DATE