

Instructions: Please Print. Fill in all blanks. If a blank does not pertain to your accident, injury or illness, write "N/A" in that blank. When completed, return this form to your supervisor.

Name:									-
Contact Number		Sex			Age		-		
Type of Incident: □Occupational Injury/Illness		□Property Damage		e =	□Violence				
	□Environmental	■Near Miss	□Vehic	le	□Fatality		□Theft		
Hire Date				Time in Preser	nt Job				
Job Title				Supervisor					
Department				Accident Date	& Time				
Accident Location				Activity at time	e of accident				
Witnesses				Witnesses					
What caused the A	ccident/Incident		Se	e reverse side	e for addition	nal details	s how accid	lent/incide	ent happened ⊏
What caused the A	ccident/Incident								
What could have p	revented this accident								
Date & Time you first so	ught medical attention								
Name of Hospital or Doo	ctor								
Were you using required	d safety equipment?								
Do you have a job at an	other company?								

Describe how the accident/incident happened	
Document and document in the province	
Manager (Company) and the Company of	
Manager/Supervisor Recommendation for correction action:	
The information I have provided either in my own writing or ve	erbally for the purpose of this form is true and correct. I
understand that providing false or misleading information or o	mission of information on this report or any other form
relating to this claim of injury/accident may result in termination	of my employment.
Signature of Employee:	Date:
	<del></del>
Signature of Manager:	Date: