*To be completed by the supervisor with the worker immediately after an accident/incident (Please Print)*

1. **GENERAL INFORMATION**

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Last Name |  | First Name |  | | | | Emp. ID |  |
| Type | Full time [ ] Part time [ ] Casual [ ] Temp FT [ ] Temp PT [ ] Temp Casual [ ] | | | | | | | | |
| Job Title/  Occupation |  | Hire  Date | MM | DD | YYYY | Lenth of Time  in Position | |  | |

1. **ACCIDENT/ILLNESS INVESTIGATION**

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **1. INCIDENT/ACCIDENT**  **REPORTED TO:** | | | |  | | | | | | | | | **JOB TITLE:** |  | | | | | |
| **2. DATE OF INCIDENT/ACCIDENT:** | | | | **TIME OF INCIDENT/ACCIDENT:** | | | | | | | **dATE INCIDENT/ACCIDENT**  **REPORTED:** | | | | | **TIME INCIDENT/ACCIDENT REPORTED:** | | | |
| MM | DD | YYYY | |  | am |  | | | pm | | MM | | DD | YYYY | |  | am |  | pm |
| **3. WHAT JOB WAS THE WORKER PERFORMING:** | | | | | |  | | | | | | | | | | | | | |
| **4. WAS THIS PART OF REGULAR DUTIES** | | | | | | Yes [ ] No [ ] | | | | | | | | | | | | | |
| **5. EXACT LOCATION OF INCIDENT/ACCIDENT:** | | | | | |  | | | | | | | | | | | | | |
| **6. IF INCIDENT/ACCIDENT WAS NOT REPORTED IMMEDIATELY, PROVIDE REASON:** | | | | | | | | | | | | | | | | | | | |
| **7. Describe SEQUENCE OF EVENTS LEADING TO ACCIDENT. ATTACH SKETCH IF NECESSARY.** | | | | | | | | | | | | | | | | | | | |
| People: | | |  | | | | | | | | | | | | | | | | |
| Equipment: | | |  | | | | | | | | | | | | | | | | |
| Material: | | |  | | | | | | | | | | | | | | | | |
| Environment: | | |  | | | | | | | | | | | | | | | | |
| Process: | | |  | | | | | | | | | | | | | | | | |
| Additional comments: | | |  | | | | | | | | | | | | | | | | |
| **8. DESCRIBE ANY UNSAFE ACT INVOLVED** | | | | | | |  | | | | | | | | | | | | |
| **9. DESCRIVE ANY UNSAFE MECHANICAL OR PHYSICAL CONDITION INVOLVED** | | | | | | |  | | | | | | | | | | | | |
| **10. GENERAL TYPE OF ACCIDENT/ ILLNESS**  **(AS PER FORM 7)** | | | | | | | Struck/Caught [ ] Fall [ ] Slip/Trip [ ]  Overexertion [ ] Harmful Substances/Environmental [ ]  Repetition [ ] Assault [ ] Motor Vehicle Incident [ ]  Fire/Explosion [ ] Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | |
| **11. IF MORE THAN ONE TYPE OF ACCIDENT OCCURRED, PLEASE PROVIDE DETAILS:** | | | | | | | | | | | | | | | | | | | |
| **12. AREA OF INJURY (AS PER FORM 7)** | | | | | **Please check all that apply** | | | | | | | | | | | | | | |
| Head [ ] Teeth [ ] Upper back [ ]  Face [ ] Neck [ ] Lower back [ ]  Eyes [ ] Chest [ ] Abdomen [ ]  Ears [ ] Pelvis [ ]  Other\_\_\_\_\_\_\_\_\_\_ | | | | | Left Right  [ ] Shoulder [ ]  [ ] Arm [ ]  [ ] Elbow [ ]  [ ] Forearm [ ]  [ ] Wrist [ ] | | | | | | | Left Right  [ ] Hand [ ]  [ ] Fingers [ ]  If finger, which one? \_\_\_\_\_  [ ] Toes [ ]  If toe, which one?\_\_\_\_\_ | | | | Left Right  [ ] Hip [ ]  [ ] Thing [ ]  [ ] Knee [ ]  [ ] Lower Leg [ ]  [ ] Ankle [ ]  [ ] Foot [ ] | | | |
| **13. are you aware of any prior similar or related problem, injury or condition** | | | | | | | | YES | | NO | | **If “yes”,**  **please explain** | | |  | | | | |
| **14. if you have concerns about this accident/illness, attach a written submission to this form.** | | | | | | | | | | | | submission attached | | | | | | | |

**C. WITNESS STATEMENT**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **2. WITNESS’ NAME:** |  | | **JOB TITLE:** |  |
| **3. WITNESS’ NAME:** |  | | **JOB TITLE:** |  |
| **4. EXACT LOCATION OF INCIDENT/ACCIDENT:** | |  | | |
| **5. aT THE TIME OF THE INCIDENT/ACCIDENT, WHERE WERE YOU LOCATED?** | | | | |
|  | | | | |
| **6. describe what happened before the accident and during the accident.** | | | | |
|  | | | | |

|  |  |  |
| --- | --- | --- |
| **1. ARE THERE ANY WITNESSES? If yes, please ensure witness statements are completed** | YES [ ] | NO [ ] |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **7. To the best of my knowledge, all information in this “Witness Statement” is true.** | | | | | |
| NAME OF WITNESS: | SIGNATURE: | DATE: | MM | DD | YYYY |
| NAME OF WITNESS: | SIGNATURE: | DATE: | MM | DD | YYYY |

### D. HEALTH CARE/MEDICAL AID INFORMATION

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **1. DID THE WORKER RECEIVE HEALTH CARE**  **FOR THIS INJURY?** | | | | | YESNO  UNKNOWN | | | | | IF YES, WHEN | | | MM | DD | | YYYY |
| **2. DID THE WORKER RECEIVE FIRST AID?** | | | | | | YES NO | | EMPLOYEE REFUSED FIRST AID TREATMENT | | | | | | | | |
| **3. name of first aid attendant:** | | |  | | | | | | | | | | | |  | |
| **4. DESCRIPTION OF FIRST AID GIVEN** | | | |  | | | | | | | | | | | | |
| **5. WHERE WAS THE WORKER TREATED FOR THIS INJURY IF OUTSIDE OF the company** | | | | | | | | | | |  | | | | | |
| **6. NAME OF hospoital or clinic** | |  | | | | | | | **NAME OF**  **PHYSICIAN:** | | |  | | | | |
| **ADDRESS:** |  | | | | | | | | **PHONE #:** | | |  | | | | |
| **7. METHOD OF TRANSPORTATION TO MEDICAL FACILTY:** | | | | | | | Taxi [ ] Ambulance [ ] | | | | | | | | | |
| **8. Additional info:** | | | | | | | | | | | | | | | | |

### E. LOST TIME – NO LOST TIME

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **1. PLEASE CHOOSE ONE OF THE FOLLOWING INDICATORS – AFTER THE DAY OF ACCIDENT/AWARENESS OF ILLNESS, THIS WORKER:**  Returned to his/her **regular job** and **has not** lost any time and/or earnings  Returned to **modified work** and **has not** lost any time and/or earnings  **Has** lost time and/or earnings | | | | | | | | | | | | | | |
| **dATE EMPLOYEE LEFT WORK:** | | | **TIME EMPLOYEE LEFT WORK:** | | | | **DATE EMPLOYEE RETURNED**  **TO WORK (if known):** | | | | **TIME EMPLOYEE RETURNED**  **TO WORK:** | | | |
| MM | DD | YYYY |  | am |  | pm | MM | DD | | YYYY |  | am |  | pm |
| **2. IF THE EMPLOYEE RETURNED TO WORK, WHAT TYPE OF WORK ARE THEY DOING?** | | | | | | | | | Regular workModified work | | | | | |

### F. RETURN TO WORK INFORMATION

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **1. HAs THE INDIVIDUAL BEEN PROVIDED WITH WORK LIMITATIONS FOR THIS WORKER’S INJURY?** | | YESNO | | **2. HAS MODIFIED WORK BEEN DISCUSSED WITH THIS WORKER?** | | YESNO |
| **3. HAS MODIFIED WORK BEEN OFFERED TO THE WORKER?** | YESNO | | **IF “YES”, WAS IT** | | ACCEPTEDDECLINED  If declined, please attach a copy of the written offer given to the worker. | |

### G. CAUSES OF INCIDENT/ACCIDENT

|  |  |  |  |
| --- | --- | --- | --- |
| UNSAFE ACTS/PRACTICES | Operating equipment without authority | Failure to warn | |
|  | Failure to secure | Operating at improper speed | |
|  | Failure to follow procedures | Removing or making safety devices inoperable | |
|  | Using defective equipment | Using equipment improperly | |
|  | Failing to use personal protective equipment properly | Improper loading | |
|  | Improper placement | Improper lifting | |
|  | Improper position for task | Servicing equipment in operation | |
|  | Horseplay | Under influence of alcohol and/or other drugs | |
|  |  |  | |
| UNSAFE CONDITIONS | Inadequate guards or barriers | Inadequate or improper protective equipment | |
|  | Defective tools, equipment or materials | Congestion or restricted action | |
|  | Inadequate warning system | Fire and explosion hazards | |
|  | Poor housekeeping; disorder; congestion | Noise exposures | |
|  | Radiation exposures | High or low temperature exposures | |
|  | Inadequate or excess illumination | Inadequate ventilation | |
|  | Hazardous environmental conditions: gases, dusts, smoke, fumes, vapours | | |
|  |  | |  |
| OTHER FACTORS | Lack of training | | Lack of knowledge and/ or skills |
|  | Failure to recognize a hazard | | Stress |
|  | Inadequate leadership/supervision | | Inadequate maintenance |
|  | Inadequate tools/equipment | | Inadequate engineering or design |
|  | Wear and tear | | Abuse or misuse |
|  |  | |  |
| EXPLAIN: |  | | |

### H. ACTION PLAN

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **ROOT CAUSE/CONTRIBUTING FACTORS** | | **RECOMMENDED CORRECTIVE ACTIONS TO PREVENT RECURRENCE** | | **TO BE DONE BY**  **(name & department)** | **DUE DATE** |
| 1. |  | 1. |  |  |  |
| 2. |  | 2. |  |  |  |
| 3. |  | 3. |  |  |  |
| 4. |  | 4. |  |  |  |
| 5. |  | 5. |  |  |  |
| 6. |  | 6. |  |  |  |
| EXPLAIN: | |  | | | |

### I. DIAGRAMS

|  |
| --- |
| Diagrams or photographs may be placed here: |

### J. SIGNATURES

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| NAME OF DEPARTMENT SUPERVISOR/TEAM LEADER: | SIGNATURE: | DATE: | MM | DD | YYYY |
| NAME OF DEPARTMENT MANAGER: | SIGNATURE: | DATE: | MM | DD | YYYY |
| NAME OF JHSC WORKER MEMBER: | SIGNATURE: | DATE: | MM | DD | YYYY |
| NAME OF INJURED EMPLOYEE | SIGNATURE: | DATE: | MM | DD | YYYY |