THE UNIVERSITY OF WESTERN ONTARIO  
Accident/Incident Reporting Form & Investigation Report  
FAX COMPLETED FORM TO:  519-661-2079 (82079)  
MAIL TO: Room 294, Stevenson-Lawson Building, Rehabilitation Services

SECTION #1 – Accident/Incident Reporting Form

PART A

Name of Employee: ____________________________________ Employee Number: ______________________

Employee Group (if applicable): □ UWOSA □ PMA □ CUPE 2361 □ CUPE 2692 □ IUOE □ PSAC 610 □ SAGE □ UWOF □ UWOPA

Status: □ RF □ RP/TM □ CW □ Undergrad Student □ Grad Student □ Other/Visitor

Type: □ Report Only □ Accident □ Incident □ No Injury/Hazard □ First Aid □ Lost Time □ Non-Lost Time

(If Report Only, please complete Section #1 - Parts A, B, and F – Supervisor will retain report and give copy to employee)

PART B

Date & Time of Accident/Incident: _________________ Time: _________ a.m/p.m

Day/Month/Year

Date & Time Accident/Incident Reported: ________________ Time: _________ a.m/p.m.

Day/Month/Year

Description of Accident/Incident: (What happened to cause the accident/incident? What was the person doing? Was there any equipment, people or materials involved- identify the size, weight and type)

____________________________________________________________________________________________________________________________________

____________________________________________________________________________________________________________________________________

____________________________________________________________________________________________________________________________________

____________________________________________________________________________________________________________________________________

____________________________________________________________________________________________________________________________________

Part of body injured (specify left or right side):

____________________________________________________________________________________________________________________________________

Location/Area of Accident/Incident or Hazardous Situation (Building and Rm #):

____________________________________________________________________________________________________________________________________

Name & Contact Information of Witness(es):

(If there are witnesses, please include a statement from each witness)

PART C

Treatment of Injury:

1. Did the Employee/Student receive First Aid and by whom? YES □ NO □

If YES, give treatment details: _________________________________________________________________

2. Did the Employee/Student visit Workplace/Student Health? YES □ NO □

3. Did the Employee visit Hospital and/or Physician? YES □ NO □

If YES, what hospital/physician, date & time, address, phone number & give transportation details (e.g. ambulance):

____________________________________________________________________________________________________________________________________

To your knowledge, has the person had a similar disability? If YES, please explain below YES □ NO □

____________________________________________________________________________________________________________________________________
SECTION #2 – Investigation Report

PART D
Immediately investigate if any of the following occur: Fatalities, Critical Injuries, Lost Time, Occupational Illness, Property Damage, Fire or Environmental Release

Is the employee off work due to this accident/incident? □ Yes □ No

Date & Hour Last Worked: ____________________ a.m./p.m.

Normal Working Hours & Days:

<table>
<thead>
<tr>
<th>Day/Month/Year/Time</th>
<th>Sun</th>
<th>Mon</th>
<th>Tue</th>
<th>Wed</th>
<th>Thu</th>
<th>Fri</th>
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<tbody>
<tr>
<td>Time</td>
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<td>Hours</td>
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Employee Return to Work Date: _________________ a.m./p.m.

PART E
Contributing Factors (Check ✓ applicable factors):

□ Hazardous method/procedure used
□ Improper position/posture (ergonomics)
□ Inadequate personal protective equipment
□ Incorrect/defective tools
□ Unsafe design or construction
□ Poor weather conditions
□ Hazardous housekeeping or arrangement
□ Inexperience of person in the task
□ Training/job instruction inadequate
□ Inadequate guarding of material & equipment
□ Inadequate lighting/ventilation
□ Other: _________________________________

Detail Factors: _________________________________

Actions and Follow up to prevent Recurrence:

□ Contact Occupational Health & Safety for assistance
□ Contact Physical Plant Department for assistance
□ Actions to improve design/procedures
□ Correct congested area
□ Repair or replace tool/equipment
□ Improve personal protective equipment
□ Install guard or safety device
□ Reinstruct person involved & provide support/coaching
□ Request Ergonomic Assessment
□ Update training
□ Refer to Rehabilitation Services

** Supervisor to provide a detailed Action Plan below**

ACTION PLAN

<table>
<thead>
<tr>
<th>Action Plan (include what, why &amp; how recommendations are made)</th>
<th>Party Responsible</th>
<th>Completed Date</th>
<th>Follow Up</th>
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PART F

Name of Supervisor: ________________________  (print name)  Telephone Number: ___________________

Supervisor Signature: _________________________________________  Date: __________________

Management (Department Chair or Unit Head) Signature:

__________________________________________________________  Date: __________________

JOHSC Rep Signature: ______________________________________  Date: __________________
(if applicable)

OHS Signature:  ____________________________________________  Date: __________________
(if applicable)

Employee Signature: ________________________________________  Date: __________________

PART G

Distribution List:

Distribute copies to:

(Supervisor to do)

1) Workplace/Student Health Services (UCC 25)  ______
2) Budget Unit Head/Supervisor or Chair  ______
3) Employee/Student/Visitor  ______
4) Originator  ______
5) Applicable Employee’s Union/Staff Group – JOHSC Rep
   UWOSA-UCC 255  ______
   PMA-UCC 351  ______
   CUPE 2361 PPD-SB  ______
   CUPE 2692 Food Services-Perth Hall 152  ______
   UWOPA-SLB 57G  ______
   IUOE-SB  ______
   PSAC 610-UCC 270  ______
   SAGE-SLB 212G  ______
   UWOF-A-ELBORN  ______
WITNESS STATEMENT *(Include for each witness when submitting AIIR)*

Name of Witness: ________________________________________________________________

Contact Information: ______________________________________________________________

Phone/Ext: ______________________________________________________________________

Date and Time of Accident/Incident: _________________________________________________

Injured Worker’s Name: __________________________________________________________

Location of Accident/Incident: _____________________________________________________

Your Account of the Accident/Incident:
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Name of Witness: ___________________________  Date: __________________________

Signature of Witness: ____________________________________________________________