Accident/Illness/Incident (AII) Reporting Form & Investigation Report

Email Completed Form (*within 24 hours)* to: uwoaiir@uwo.ca
or Fax to: 519-661-3420

CLEAR FORM

SECTION #1 – Accident/Illness/Incident Reporting Form

PART A

Name of Employee: _____ **Employee Number:** _____

Contact Telephone Number of Employee: (Home)_____ **(Cell)**_____

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

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

Type: □ Occ. Illness □Accident □Incident □No Injury/Hazard □ First Aid □ Lost Time □ Non-Lost Time

PART B

Date & Time of AII: _____ Day/Month/Year **Time:** _____ a.m/p.m

Date & Time AII Reported: _____ Day/Month/Year **Time:** _____ a.m/p.m.

Description of Accident/Illness/Incident:(*What happened to cause the AII? 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 AII 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 AII ? ☐ **Yes** ☐ **No**

Date & Hour Last Worked: _____ a.m./p.m.
Day/Month/Year/Time

Employee Return to Work Date: _____ a.m./p.m.
Day/Month/Year/Time

Normal Working Hours & Days:

	Sun	Mon	Tue	Wed	Thu	Fri	Sat
Time							
Hours							

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

Action Plan(include what, why & how recommendations are made)	**Party Responsible**	**Completed Date**	**Follow Up**

PART F

INVESTIGATED BY:

Name of Supervisor: _____ (print name) Telephone Number: _____

Supervisor Signature: _____ Date: _____

REVIEWED BY:

Management (Department Chair or Unit Head) Signature:

_____ Date: _____

Employee Signature: _____ Date: _____

JOHSC Rep Signature: _____ Date: _____
(if applicable)

OHS Signature: _____ Date: _____
(if applicable)

****FAX COMPLETED FORM TO 519-661-3420 OR EXT 83420 (ON CAMPUS)****

PART G Distribution List:

Initial - Sent Off:

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 FM-SSB 1320* _____
   - *CUPE 2692 HS -Perth Hall 152* _____
   - *UWOPA-LwH 1257* _____
   - *IUOE* _____
   - *PSAC 610-UCC 270* _____
   - *SAGE-STvH 3107P* _____
   - *UWOFA-ELBORN* _____
6) *Unit/Department Health & Safety Officer* _____

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:

Name of Witness: _____ **Date:** _____

Signature of Witness: _____

ADDITIONAL INFORMATION

Name: _____ **Date:** _____

Signature: _____