Check Only One Box

1 □ INJURY
2 □ ACCIDENT
3 □ NEAR MISS
4 □ SPILL

INVESTIGATION REPORT

FOR ACCIDENT(EQUIP. DAMAGE), NEAR MISS, SPILL OR PERSONAL INJURY

***Attach photos, sketches or diagrams 2014-JUNE-20

To Be Completed By Employee → To Be Completed By Manager → Safety Co → Dept Head → OHC

Employee Name and Address	**Employee #**

Date of Incident			**Date Reported**			**Department Name**
YY	MM	DD	YY	MM	DD	

Date of Incident	**Date Reported**	**Regular Hours on Incident Date**
HH:MM □ AM □ PM	HH:MM □ AM □ PM	**From** HH:MM □ AM □ PM **To** HH:MM □ AM □ PM

Plate/unit #	Other Driver Info: (name, address, plate, pic #, description of vehicle)
Driver PIC #	
Licence class	

Employee's Job Title at Time of Incident and status (casual or perm)	**Length of Experience on Job (YY/MM)**

Street Address of Incident	**Exact Location (Where in building, park, street, etc.)**	**Names of Witness(es)**
		1. 2. 3. 4.

Detailed Description of Incident (Include equipment description and attach sketch/pictures)

Causes of Incident	**Protective Equipment Required for this Work**	**Protective Equipment Worn at Time of Incident**
	□ Gloves □ Safety Shoes □ Eye Protection (Goggles) □ Hard Hat □ Respirator System □ Other _____	□ Gloves □ Safety Shoes □ Eye Protection (Goggles) □ Hard Hat □ Respirator System □ Other _____

Recommended Action Plan

Date to be completed:_____

Employee's Signature (sent to manager)

Other Background Information	**Yes**	**No**
▪ Was employee experienced in work operation?	□	□
▪ Was all specified protective equipment used at time of incident?	□	□
▪ Was there failure of equipment?	□	□
▪ Were proper work methods followed?	□	□
▪ Was there a re-enactment of the conditions and events that led up to this incident?	□	□

▪ **Was similar work operation ever discussed with employee?**
Yes □ No □ If Yes, When? YY / MM / DD

▪ **Has employee attended an orientation session that related to this type of incident? (i.e.. Back care, defensive driving…)**
Yes □ No □ If Yes, When? YY / MM / DD

Signature of Manager (to Safety) **Date Signed** YY / MM / DD

Body Parts Injured

Print "1" beside body part most seriously injured
Print "2" beside body part next most seriously injured and so on

Both Arms	□ _____	Both Feet	□ _____	Internal	□ _____
Left Arm	□ _____	Left Foot	□ _____	Both Legs	□ _____
Right Arm	□ _____	Right Foot	□ _____	Left Leg	□ _____
Back	□ _____	Both Hands	□ _____	Right Leg	□ _____
Both Eyes	□ _____	Left Hand	□ _____	Trunk	□ _____
Left Eye	□ _____	Right Hand	□ _____	Other	□ _____
Right Eye	□ _____	Head	□ _____	_____	

Main Type of Injury (Check One Box)

□ Amputation
□ Bruise or Contusion
□ Burn
□ Concussion
□ Cut or Puncture
□ Foreign Body in Eye
□ Fracture or Dislocation
□ Hernia
□ Inhalation or Ingestion
□ Rash or Dermatitis
□ Sprain or Strain
□ Other _____

Classification (Check Appropriate Boxes)

Untreated □ 1 First Aid □ 2 Medical Aid □ 3 Lost Time □ 4

Additional Action taken/comments (OHS Coordinator)	**Sign & Print (to dept. head)**	**Date Signed**

Short and long term solutions	**Who will implement planned preventative measures and when?**
Date to be completed: _____	Date to be completed: _____
	Signature of Dept. Head or Designate(to OHC) **Date Signed**

Remarks of OHC Co-Chairs (to OHC admin. to distribute copies)	**Sign & Print**	**Date Signed**
	Sign & Print	**Date Signed**

Distribution After Completion (check when copies sent) Finance and fleet only copied on equipment damage

□ **Department Head** □ **Finance (if applic.)** □ **OHC** □ **Human Resources** □ **Fleet Manager (if applic.)**