University of Windsor

ACCIDENT / INCIDENT INVESTIGATION REPORT

Relevant sections must be completed in full by employee and supervisor. **SUBMIT WITHIN 24 HOURS TO**:
Health & Safety email: safety@uwindsor.ca | fax: 519-971-3671 | For questions phone:519-253-3000 ext 4521

H&S USE ONLY: INC#

SECTION A: EMPLOYEE / INJURED PERSON INFORMATION

Last Name:	**First Name:**	**Telephone #:**

Status: ☐ Employee ☐ Student ☐ Volunteer ☐ Contractor/Service Provider ☐ Visitor ☐ Other (Specify):

SECTION B: EMPLOYMENT DETAILS (IF NOT APPLICABLE, SKIP TO SECTION C)

Department:	**Occupation (Job Title):**	**Employee #:**

Employee Group: ☐ Academic ☐ Administration (Non-Union) ☐ Union (Specify): ☐ Other (Specify):

Employment Type: ☐ Full Time ☐ Part Time ☐ Casual ☐ Sessional ☐ Temporary ☐ Other (Specify):

Employee's Date of Hire:	**Date Employee Started Current Job:**	**Rate of Pay: $** ☐ Hourly ☐ Salary ☐ Daily

Weekly Pay Hours:	**Shift Worker:** ☐ YES ☐ NO **If yes, enter shift premium per hour: $** /hr

Reg. Work Hours:	**Sun:**	**Mon:**	**Tues:**	**Wed:**	**Thurs:**	**Fri:**	**Sat:**

Does this schedule change week to week? ☐ Yes ☐ No If yes, provide details:

SECTION C: DESCRIPTION OF THE EVENT

Date of Incident:	**Time of Incident:** ☐ AM ☐ PM	**Date reported:**	**Time Reported:** ☐ AM ☐ PM

Name of Supervisor Reported to:	**Supervisor Employee #:**	**Phone Ext:**

Exact Location of Occurrence (incl. Building & Room #):

Was the accident/ illness: ☐ a sudden event ☐ gradually occurring ☐ occupational disease ☐ Other:

Nature of Injury: ☐ Cut ☐ Burn ☐ Bruise ☐ Strain/Sprain ☐ Irritation ☐ None ☐ Other:

Area of Injury: ☐Hand ☐Wrist ☐Arm ☐Foot ☐Ankle ☐Leg ☐ Back ☐ Other: **Side:** ☐ Right ☐ Left ☐ Upper ☐ Lower

Hand Dominance: ☐ Right ☐ Left **Emergency Response:** Did Special Constable Service respond to this incident? ☐ Yes ☐ No

Critical Injury: Did the injury: result in a possible fracture, produce unconsciousness, place life in jeopardy, result in substantial loss of blood, major burns, or loss of sight? ☐ Yes* ☐ No ☐ Unsure *Critical injuries must be reported to Special Constable Service / Occupational Health & Safety immediately.

Incident Type (check one only): ☐ Incident Only / Near Miss ☐ First Aid ☐ Medical Aid / Lost Time

- If property damage occurred, please contact Special Constable Service for proper reporting procedures.
- If there was a spill during the incident, please contact the Chemical Control Centre for proper reporting procedures.

If the injury requires medical aid or results in an absence from work, you must provide your Supervisor with a copy of the WSIB Form 8 (page 3) from the treating Health Professional.

Description of the incident: *(To be filled out by Supervisor & Employee together if possible. What happened to cause the injury/incident, and what was the employee doing at the time? Include any details of equipment, materials used, and environmental conditions [work area, temperature, noise, chemicals, etc]. For a gradually occurring injury, please detail the physical activities involved with the job).*

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SECTION D: WITNESSES – Please list names of any witnesses and attach statements if available.

SECTION E: PREVENTIVE AND CORRECTIVE ACTION RESULTING FROM ACCIDENT INVESTIGATION

What action has or will be taken to prevent recurrence? Attach additional action plans if required.

#	Action	Person Responsible*	Completion Date	Verified by/ Date
1				
2				
3				

*Have these items been communicated to the person responsible? ☐ YES ☐ NO.

Health & Safety Investigation Notes:

SECTION F: HEALTH CARE INFORMATION

Health Care Provided by: ☐ Health Professional Office ☐ Clinic ☐ Emergency Department ☐ Other

Name of Health Professional who provided treatment:	**Date of Medical:**	**Time of Medical:** ☐ AM ☐ PM
Address:		**Phone # (if known):**

Absent Beyond the Date of the Incident/Accident?: ☐ YES ☐ NO *Ensure page 3 of Health Professional's Form 8 is provided to Supervisor

Date Last Worked:	**Hour Last Worked:** ☐ AM ☐ PM

If **No Lost Time**, will worker require **Modified** work? ☐ **YES** ☐ **NO** **Details:**

If there was a delay in reporting the incident, list reason(s):

SECTION G: CLAIM INFORMATION

To your knowledge, has the worker had a previous similar injury / disease? ☐ YES ☐ NO

If yes, provide details and whether a similar injury was work related or not.

Was any individual who does not work for you totally or partially responsible for the injury/disease? ☐ YES ☐ NO

If yes, please explain.

SECTION H: SIGNATURES

Form completed by (Please print):	**Date:**	
Signature:	**Telephone:**	**Date:**
Supervisor (Please print): (If different than above)	**Signature:**	**Date:**
Employee (Please print):	**Signature:**	**Date:**

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