

**ILLNESS or INJURY INCIDENT REPORT**

This form must be initiated and faxed/ emailed within 24 hours of the Supervisor learning of the incident. Fax to 519-780-1796 or email to [ohw@uoguelph.ca](mailto:ohw@uoguelph.ca). Submit additional information as available.

<input type="checkbox"/> Injury
<input type="checkbox"/> First Aid <input type="checkbox"/> No First Aid <input type="checkbox"/> Health Care (Medical Aid)

<input type="checkbox"/> No Injury
Hazardous Situation

**THIS SECTION TO BE COMPLETED BY OR FOR THE AFFECTED PARTY**

<b>Who was the affected person?</b>  <input type="checkbox"/> EMPLOYEE <input type="checkbox"/> STUDENT <input type="checkbox"/> VISITOR <input type="checkbox"/> VOLUNTEER <input type="checkbox"/> CONTRACTOR	<b>Last Name:</b>	<b>First Name:</b>	<b>Initial:</b>	<b>Phone or Extension:</b>
	<b>Occupation, if applicable:</b>	<b>Department:</b>	<b>Union/Bargaining Group:</b>	
	<b>Name of Supervisor:</b>	<b>Phone or Extension:</b>	<b>Name of Dept. Head:</b>	
	<b>Date &amp; Time of Incident:</b>	<b>Date Reported to Supervisor:</b>	<b>Date Submitted:</b>	

<input type="checkbox"/> Slip, Trip or Fall <input type="checkbox"/> Electrical Shock/Burn <input type="checkbox"/> Needle/Sharp/Puncture/Cut <input type="checkbox"/> Loss of Consciousness	<input type="checkbox"/> Struck by/against Object <input type="checkbox"/> Exposure to possible hazardous/infectious material <input type="checkbox"/> Animal Bite/Sting/Scratch	<input type="checkbox"/> Muscle Strain <input type="checkbox"/> Repetitive Strain <input type="checkbox"/> Other <input type="text"/>
<b>If Slip or Fall describe footwear:</b> <input type="text"/>	Complete <a href="#">Workplace Harassment Reporting Form</a> for reporting harassment in the workplace or <a href="#">Workplace Violence Reporting Form</a> , for reporting workplace violence	

**Description of Incident:**

**Witnesses (Name/Phone Number):**

<b>Where did the incident occur?</b>	<input type="checkbox"/> Guelph Campus <input type="checkbox"/> Alfred Campus <input type="checkbox"/> Kemptville Campus <input type="checkbox"/> Ridgetown Campus <input type="checkbox"/> Research Station: <input type="text"/> <input type="checkbox"/> Other <input type="text"/>	<b>Building Name:</b>	<b>Room Number:</b>
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Cafeteria  
  Classroom  
  Hallway  
  Kitchen  
  Lab  
  Stairwell  
  Office  
  Washroom  
  In vehicle  
  Stairs  
 Loading Dock  
 Parking Lot  
 Walkway  
 Other

**What was the injury:**

**Select part of body and indicate Right (R) Left (L), both (B) or Quantity Injured in the box:**

<input type="checkbox"/> Head	<input type="checkbox"/> Teeth	<input type="checkbox"/> Pelvis	<input type="checkbox"/> Elbow	<input type="checkbox"/> Upper Back	<input type="checkbox"/> Knee	<input type="checkbox"/> Toes
<input type="checkbox"/> Face	<input type="checkbox"/> Neck	<input type="checkbox"/> Shoulder	<input type="checkbox"/> Wrist	<input type="checkbox"/> Lower Back	<input type="checkbox"/> Lower Leg	
<input type="checkbox"/> Eye	<input type="checkbox"/> Abdomen	<input type="checkbox"/> Upper Arm	<input type="checkbox"/> Hand	<input type="checkbox"/> Hip	<input type="checkbox"/> Ankle	
<input type="checkbox"/> Ear	<input type="checkbox"/> Chest	<input type="checkbox"/> Lower Arm	<input type="checkbox"/> Fingers	<input type="checkbox"/> Upper Leg	<input type="checkbox"/> Foot	

**Did you see a medical professional?**  
 No    Yes   If yes, Date of Visit:

**If yes, Name, Address and Phone Number of Medical Professional:**

**Treatment of Injury:**

Occ Health / Dept. First Aid  
  Emergency Room  
 Physician /Clinic  
  No First Aid Req'd  
 Student Health Services

Continued on Page 2

**THIS SECTION TO BE COMPLETED WITH OR BY THE SUPERVISOR**

**Contributing Factors:** What conditions contributed to the incident?

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> Operating W/O Authority   | <input type="checkbox"/> Inadequate Housekeeping                  | <input type="checkbox"/> Not or Improperly Guarded         |
| <input type="checkbox"/> Inadequate Work Procedure | <input type="checkbox"/> Improper Position/Posture                | <input type="checkbox"/> Hazardous Environmental Condition |
| <input type="checkbox"/> Failure to Lockout        | <input type="checkbox"/> Inadequate Illumination                  | <input type="checkbox"/> Inclement Weather                 |
| <input type="checkbox"/> Insufficient Training     | <input type="checkbox"/> Infraction OR Unsafe Practice            | <input type="checkbox"/> Other <input type="text"/>        |
| <input type="checkbox"/> Unsafe Equipment          | <input type="checkbox"/> Failure of Personal Protective Equipment |  |

**Explanation of Contributing Factors:**

**Details of Property Damage (if any):**

**To your knowledge, has the employee reported a previous similar injury or similar hazardous situation before?**

- No  Yes

**Corrective Measures:** Actions taken to prevent a reoccurrence (Check all that apply):

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> Control Operation / Access | <input type="checkbox"/> Perform Housekeeping              | <input type="checkbox"/> Review Personal Protective Equipment |
| <input type="checkbox"/> Improve Work Procedure     | <input type="checkbox"/> Ergonomic Assessment              | <input type="checkbox"/> Install Safety Guard / Device        |
| <input type="checkbox"/> Apply Lockout / Tag-out    | <input type="checkbox"/> Job Safety Analysis               | <input type="checkbox"/> Inform Dept. Supervision             |
| <input type="checkbox"/> Provide Training           | <input type="checkbox"/> Request Lighting Review           | <input type="checkbox"/> Inform all Staff                     |
| <input type="checkbox"/> Repair / Replace Equipment | <input type="checkbox"/> Reinstruction of Persons Involved | <input type="checkbox"/> Other <input type="text"/>           |

**Explanation of Corrective Measures:**

**Deadline to complete Corrective Measure:**

**By Whom:**

**Date Completed:**

\_\_\_\_\_  
Signature of Person Reporting Incident

\_\_\_\_\_  
Supervisor Signature

\_\_\_\_\_  
Dept. Head Signature

**Reminder:** For Health Care (Medical Aid) Injuries ensure the Injury Package is given to the employee.

**Indicate / ensure copies are distributed to:**  Dept. Head  [Union / Bargaining Group](#)  [Local JHSC](#) as appropriate

**Description of Incident continued:**

Continued on Attachment

### **Purpose of the Incident Report Form**

- To ensure compliance with Workplace Safety and Insurance Board and Occupational Health and Safety Act, which require timely reporting of occupational injury or disease.
- Information requested on this form will be used by Occupational Health and Wellness (OHW) for the completion of the required WSIB Form 7 and by the Environmental Health and Safety (EHS) to provide information to the Ministry of Labour, if required.
- The form also ensures the area supervisor is aware of, and has followed-up on, the incident/injury and/or property damage that has occurred.

**Separate and confidential forms are available for submitting details of violence and harassment. This form need only be completed with minimum details: name of affected party, supervisor, location etc.**

**How to Fill Out this Form** - The form has been divided into two sections.

The top section is to be filled out **by or for the injured person** or the person involved in a hazardous situation. Students, visitors, and volunteers may require assistance. If the injured party is unable to fill out this section, for whatever reason, it is to be completed by the area or staff member's supervisor or can be initiated by a co-worker if the supervisor is unavailable. The lower section is to be completed by the direct supervisor of the employee or of the area generating the report.

### **Injured Party Section**

- Ensure that all personal information is entered correctly and the details of the incident are documented as thoroughly as possible. Every item in this section requires an answer. Please ensure the supervisory contact information is complete.
- If you require the use of an attachment, please indicate this by checking the "continued on Attachment" on the bottom of page 2.
- The form is to be signed by the injured party/ worker (if they are able) or by the person reporting the incident, prior to faxing by the supervisor.
- **If you seek medical attention after the incident report form has been submitted**, please notify your supervisor and OHW. Your supervisor will provide you with an **Injury Package** which includes a letter that explains the process, a Functional Abilities Form (FAF), and a letter to your health care practitioner about our modified work program.

### **Supervisor Section**

- **Contributing Factors:** Check off one or more of the boxes that represent the causal factors of the incident being reported.
- For insurance reasons and/or to implement prevention strategies, ensure that any property damage is detailed in this section.
- **Corrective Measures:** Care must be taken to complete this important section. Indicate what steps were taken by the supervisor/employer to mitigate the risk(s) associated with the task and/or prevent its reoccurrence. For whatever action was taken or recommended, ensure that the details of the maintenance request/work order are outlined here. Also include the name of outside providers, where appropriate. **Document known facts only.**
- Acquire signatures before submitting form, if possible, however, **do not delay submitting the form if you cannot obtain the signature of the injured party or the department head.** This can be arranged later. Send the form into OHW so that the respective WSIB and MOL notifications can be made.
- **Ensure that the department head, respective union/bargaining group and Local JHSC, as applicable receive a copy of this form.** Indicate the distribution on this form.
- When an employee notifies you that he/she will be seeing a medical professional related to this recent incident, provide them with an **Injury Package** which includes a letter explaining the process, a **Functional Abilities Form (FAF)**, and a letter for the health care practitioner.
- The Injury Package can be found on the [OHW website](#)
- Advise the employee that modified work is available and to return the completed FAF to OHW as soon as possible.