UNIVERSITY of GUELPH

# ILLNESS or INJURY INCIDENT REPORT

**This form must be initiated and faxed within 24 hours of the Supervisor learning of the incident.**
**Fax to 519-780-1796 Submit additional information as available.**

❑ Injury
❑ First Aid
❑ No First Aid
❑ Health Care (Medical Aid)

❑ No Injury
Hazardous Situation

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

**Who was the affected person?**

❑ EMPLOYEE
❑ STUDENT
❑ VISITOR
❑ VOLUNTEER
❑ CONTRACTOR

| **Last Name:** | **First Name:** | **Initial:** | **Phone or Extension:** |
|---|---|---|---|
| **Occupation, if applicable:** | **Department:** | **Union/Bargaining Group:** | |
| **Name of Supervisor:** | **Phone or Extension:** | **Name of Dept. Head:** | |
| **Date & Time of Incident:** | **Date Reported to Supervisor:** | **Date Submitted:** | |

❑ Slip, Trip or Fall
❑ Electrical Shock/Burn
❑ Needle/Sharp/Puncture/Cut
❑ Loss of Consciousness
❑ Struck by/against Object
❑ Exposure to possible hazardous/infectious material
❑ Animal Bite/Sting/Scratch
❑ Muscle Strain
❑ Repetitive Strain
❑ Violence
❑ Harassment
❑ Submit Secondary VIOLENCE or HARASSMENT form
❑ Other

**If Slip or Fall describe footwear:**

**Description of Incident:**

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

**Where did the incident occur?**

❑ Guelph Campus ❑ Alfred Campus ❑ Kemptville Campus
❑ Ridgetown Campus ❑ Research Station:
❑ Other

**Building Name:**

**Room Number:**

❑ 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:**

| | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| ❑ Head | ❑ Teeth | ❑ Pelvis | ❑ Elbow | ❑ Upper Back | ❑ Knee | ❑ Toes | | | |
| ❑ Face | ❑ Neck | ❑ Shoulder | ❑ Wrist | ❑ Lower Back | ❑ Lower Leg | | | | |
| ❑ Eye | ❑ Abdomen | ❑ Upper Arm | ❑ Hand | ❑ Hip | ❑ Ankle | | | | |
| ❑ Ear | ❑ Chest | ❑ Lower Arm | ❑ Fingers | ❑ Upper Leg | ❑ 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

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

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

- ❑ Operating W/O Authority
- ❑ Inadequate Work Procedure
- ❑ Failure to Lockout
- ❑ Insufficient Training
- ❑ Unsafe Equipment
- ❑ Inadequate Housekeeping
- ❑ Improper Position/Posture
- ❑ Inadequate Illumination
- ❑ Infraction OR Unsafe Practice
- ❑ Failure of Personal Protective Equipment
- ❑ Not or Improperly Guarded
- ❑ Hazardous Environmental Condition
- ❑ Inclement Weather
- ❑ Other

**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):

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

**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.