

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. Submit additional information as available.

Injury

First Aid
No First Aid
Health Care
(Medical Aid)

NO Injury
(hazardous situation)

Possible Exposure
Near Miss

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 (ex. 6/14/22 9:46 am):	Date & Time Reported to Supervisor (ex. 6/14/22 10:19 am):	Date & Time Submitted (ex. 6/14/22 11:01 am):	

Slip, Trip or Fall
Electrical Shock
Needle/Sharps-Puncture
Loss of Consciousness
Cut

Struck by Object
Exposure to possible hazardous /
infectious material
Animal Bite/Sting/Scratch (circle one)
Burn
Struck against Object

Muscle Strain
Repetitive Strain
Other

Complete [Workplace Harassment Reporting Form](#)
for reporting harassment in the workplace or
[Workplace Violence Reporting Form](#), for reporting
workplace violence

If Slip or Fall describe footwear:

Description of Incident: Please limit description to two sentences and use second page if needed

Witnesses (Name/Phone Number):

Where did the incident occur?

Guelph 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:

Area of Injury (Body Part) - (Please check all that apply)

Head	Teeth	Upper Back	Left	Right	Left	Right	Left	Right	Left	Right
Face	Neck	Lower Back	Shoulder		Wrist		Hip		Ankle	
Eye(s)	Chest	Abdomen	Arm		Hand		Thigh		Foot	
Ear(s)		Pelvis	Elbow		Fingers		Knee		Toe(s)	
Other:			Forearm				Lower Leg			

Did you see a medical professional?

No Yes *If yes, Date of Visit (m/d/yy):

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

Treatment of Injury:

First Aid
Physician Office /Clinic
Student Health Services
Other

Emergency Room
No First Aid Req'd

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THIS SECTION TO BE COMPLETED WITH OR BY THE SUPERVISOR**Contributing Factors:** What conditions contributed to the incident?

Operating Without 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
Re-instruction 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 (m/d/yy):****By Whom:****Date Completed****(m/d/yy):**

Signature of Person Reporting Incident**Printed Name of Reporting Person:**

Supervisor Signature**Printed Supervisor Name:**

Dept. Head Signature**Printed Dept. Head Name:**

Reminder: For Health Care (Medical-Aid) Injuries the Injury Package must be given to the employee.

By checking this box you have confirmed this [Injury Package](#) is given to the employee (if applicable)

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

Description of Incident continued:

Continued on Attachment

Purpose of the Incident Report Form

- To confirm 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.

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

- Confirm 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 confirm 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 even 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, confirm 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 re-occurrence.
- For whatever action was taken or recommended, confirm 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 and printed names 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.
- **Confirm 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.
- If an employee has incurred a health care injury where professional medical attention is sought please provide them with the [Injury Package](#) and check the box to confirm that you have done so. The [Injury Package](#) includes a letter explaining the process, a **WSIB Functional Abilities Form (FAF)**, and a letter for the health care practitioner. Please note that the Injury Package should be provided at any time (even after an incident report is submitted) when an employee notifies you that he/ she will be seeking a medical professional related to a workplace incident.
- 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.