

# 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.

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**

<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>	

- 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  
 Other

If Slip or Fall describe footwear:

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

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

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

<b>Where did the incident occur?</b>	<input type="checkbox"/> Guelph Campus	<b>Building Name:</b> <input type="text"/>	<b>Room Number:</b> <input type="text"/>
	<input type="checkbox"/> Ridgetown Campus <input type="checkbox"/> Research Station: <input type="text"/>		
	<input type="checkbox"/> Other <input type="text"/>		

- 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:

**Treatment of Injury:**  
 Occ Health / Dept. First Aid    Emergency Room  
 Physician /Clinic    No First Aid Req'd  
 Student Health Services

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

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 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 / 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 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, 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.
- 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.