UNIVERSITY OF GUELPH

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

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):

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**
- ☐ **Face**
- ☐ **Eye(s)**
- ☐ **Ear(s)**
- ☐ **Teeth**
- ☐ **Neck**
- ☐ **Chest**
- ☐ **Upper Back**
- ☐ **Lower Back**
- ☐ **Abdomen**
- ☐ **Pelvis**

Other:

Left		**Right**
☐	**Shoulder**	☐
☐	**Arm**	☐
☐	**Elbow**	☐
☐	**Forearm**	☐

Left		**Right**
☐	**Wrist**	☐
☐	**Hand**	☐
☐	**Fingers**	☐

Left		**Right**
☐	**Hip**	☐
☐	**Thigh**	☐
☐	**Knee**	☐
☐	**Lower Leg**	☐

Left		**Right**
☐	**Ankle**	☐
☐	**Foot**	☐
☐	**Toe(s)**	☐

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	**Supervisor Signature**	**Dept. Head Signature**
Printed Name of Reporting Person:	**Printed Supervisor Name:**	**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 l ower 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.