An “accident investigation report” must be completed by supervisors whose employees were involved in an accident during working hours. The report will be completed using the standard “accident investigation report” form (see attached). Upon completion, copies of the report will be forwarded to Rehabilitation Services as soon as possible, but within 24 hours of the employee accident.

It is the responsibility of the Supervisor to ensure that all sections of the report are accurately completed and all the required information is provided. For example, in the describing the accident, it is essential that the work being carried out at the time of the accident (or employee’s activities) be specified on the report form.

Under the section “Actions to Prevent Incident Recurrence”, it is essential that the Supervisor states any recommendations, suggestions or changes in procedure(s) which will be implemented to prevent a similar accident from occurring in the future.

Following completion of the Accident Investigation Report form, the Supervisor will be responsible for advising the Rehabilitation Coordinator Office of any medical examination, medical treatment or time off from work which may have resulted from the initial accident.

Accident Investigation Reports completed by Building Services Supervisors must be submitted to the Building Manager first, and then to the Director or Associated Director, Building Services, and then to the FM Administrative Assistant.

Accident Investigation Reports completed by Trades Managers will be submitted first to the Executive Director, Facilities Operations, and then to the FM Administrative Assistant.

All Accident Investigation Reports will be routed to Occupational Health and Safety, Workplace Health and Department Manager by the FM Administrative Assistant.

All accidents in the workplace must be investigated immediately by the appropriate supervisors and corrective measures must be implemented to prevent re-occurrence.
# Accident/Illness/Incident (AII) Reporting Form & Investigation

**Report FAX COMPLETED FORM (Within 24 hours) TO:** 519-661-2079 (82079) **MAIL TO:** Room 4159, Support Services Building, Rehabilitation Services

## SECTION #1 – Accident/Illness/Incident Reporting Form

### PART A

<table>
<thead>
<tr>
<th>Name of Employee: ___________________________</th>
<th>Employee Number: __________________________</th>
</tr>
</thead>
<tbody>
<tr>
<td>Contact Telephone Number of Employee: (Home)</td>
<td>(Cell)</td>
</tr>
</tbody>
</table>

**Employee Group (if applicable):**
- UWOSA
- PMA
- CUPE 2361
- CUPE 2692
- IUOE
- PSAC 610
- SAGE
- UWFA
- UWOPA
- RP/TM
- CW
- Undergrad Student
- Grad Student
- Other/Visitor

**Status:**
- RF
- RP/TM
- CW
- Undergrad Student
- Grad Student
- Other/Visitor

**Type:**
- Occ. Illness
- Accident
- Incident
- No Injury/Hazard
- First Aid
- Lost Time
- Non-Lost Time

### PART B

**Date & Time of AII:**

<table>
<thead>
<tr>
<th>Date/Time of AII:</th>
<th>Day/Month/Year</th>
<th>Time: __________ a.m/p.m.</th>
</tr>
</thead>
</table>

**Date & Time AII Reported:**

<table>
<thead>
<tr>
<th>Date &amp; Time AII Reported:</th>
<th>Day/Month/Year</th>
</tr>
</thead>
</table>

**Description of Accident/Illness/Incident:**

*What happened to cause the AII? What was the person doing? Was there any equipment, people or materials involved - identify the size, weight and type)*

________________________________________________________________________________________

________________________________________________________________________________________

________________________________________________________________________________________

________________________________________________________________________________________

________________________________________________________________________________________

**Part of body injured (specify left or right side):**

________________________________________________________________________________________

**Location/Area of AII or Hazardous Situation (Building and Rm #):**

________________________________________________________________________________________

**Name & Contact Information of Witness(es):**

*(If there are witnesses, please include a statement from each witness)*

### PART C

**Treatment of Injury:**

1. **Did the Employee/Student receive First Aid and by whom?**
   - YES □ NO □
   - If YES, give treatment details: ___________________________________________________________________________________________

2. **Did the Employee/Student visit Workplace/Student Health?**
   - YES □ NO □

3. **Did the Employee visit Hospital and/or Physician?**
   - YES □ NO □
   - If YES, what hospital/physician, date & time, address, phone number & give transportation details (e.g. ambulance): ___________________________________________________________________________________________

**To your knowledge, has the person had a similar disability? If YES, please explain below**

- YES □ NO □
**SECTION #2 – Investigation Report**

**PART D**
*Immediately investigate if any of the following occur: Fatalities, Critical Injuries, Lost Time, Occupational Illness, Property Damage, Fire or Environmental Release*

Is the employee off work due to this AII? □ Yes □ No

**Date & Hour Last Worked:** [__] a.m./[__] p.m.  
**Day/Month/Year/Time**

**Normal Working Hours & Days:**

<table>
<thead>
<tr>
<th></th>
<th>Sun</th>
<th>Mon</th>
<th>Tue</th>
<th>Wed</th>
<th>Thu</th>
<th>Fri</th>
<th>Sat</th>
</tr>
</thead>
<tbody>
<tr>
<td>Time</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Hours</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Employee Return to Work Date:** [__] a.m./[__] p.m.  
**Day/Month/Year/Time**


**PART E**

**Contributing Factors (Check √ applicable factors):**

| □ | Hazardous method/procedure used | □ | Inadequate guarding of material & equipment |
| □ | Improper position/posture (ergonomics) | □ | Inadequate lighting/ventilation |
| □ | Inadequate personal protective equipment | □ | Other: __________________________________________________________________________|
| □ | Incorrect/defective tools | | |
| □ | Unsafe design or construction | | |
| □ | Poor weather conditions | | |
| □ | Hazardous housekeeping or arrangement | | |
| □ | Inexperience of person in the task | | |
| □ | Training/job instruction inadequate | | |

**Actions and Follow up to prevent Recurrence:**

□ Contact Occupational Health & Safety for assistance  
□ Contact Physical Plant Department for assistance  
□ Actions to improve design/procedures  
□ Correct congested area  
□ Repair or replace tool/equipment  
□ Improve personal protective equipment  
□ Install guard or safety device  
□ Reinstruct person involved & provide support/coaching  
□ Request Ergonomic Assessment  
□ Update training  
□ Refer to Rehabilitation Services

**ACTION PLAN**

**Action Plan** (include what, why & how recommendations are made)  

<table>
<thead>
<tr>
<th>Party Responsible</th>
<th>Completed Date</th>
<th>Follow Up</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
PART F

INVESTIGATED BY:

Name of Supervisor: ___________________________ (print name)  Telephone Number: ____________________

Supervisor Signature: ___________________________  Date: ______________

REVIEWED BY:

Management (Department Chair or Unit Head) Signature:

_________________________________________________  Date: ______________

Employee Signature: ___________________________  Date: ______________

JOHSC Rep Signature: ___________________________  Date: ______________
(if applicable)

OHS Signature: ________________________________  Date: ______________
(if applicable)

**FAX COMPLETED FORM TO 519-661-2079 OR EXT 82079 (ON CAMPUS)**

PART G Distribution List:

Distribute copies to:  1) Workplace/Student Health Services (UCC 25)
(Supervisor to do)  2) Budget Unit Head/Supervisor or Chair
  3) Employee/Student/Visitor
  4) Originator
  5) Applicable Employee’s Union/Staff Group – JOHSC Rep
    UWOSA-UCC 255  _______
    PMA-UCC 351  _______
    CUPE 2361 FM-SSB 1320  _______
    CUPE 2692 HS -Perth Hall 152  _______
    UWOPA-LwH 1257  _______
    IUOE  _______
    PSAC 610-UCC 270  _______
    SAGE-STvH 3107P  _______
    UWOFA-ELBORN  _______

Initial - Sent Off:
WITNESS STATEMENT *(Include for each witness when submitting AIIR)*

| Name of Witness: | ____________________________________________ |
| Contact Information: | ____________________________________________ |
| Phone/Ext: | ____________________________________________ |
| Date and Time of Accident/Incident: | ____________________________________________ |
| Injured Worker’s Name: | ____________________________________________ |
| Location of Accident/Incident: | ____________________________________________ |
| Your Account of the Accident/Incident: |  |
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Name of Witness: __________________________________ Date: ______________________

Signature of Witness: __________________________________