POLICY: ACCIDENT INVESTIGATION REPORTS			NUMBER: S-11
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PREPARED BY: Facilities Management (FM)	**AUTHORIZED BY** Lynn Logan	**CLASSIFICATION:** Safety Procedure	**EFFECTIVE:** July 1, 2015
			SUPERSEDES: December 1, 2004

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

Name of Employee: _____ **Employee Number:** _____

Contact Telephone Number of Employee: (Home)_____ **(Cell)**_____

Employee Group*(if applicable)*: □ UWOSA □ PMA □ CUPE 2361 □ CUPE 2692 □ IUOE □ PSAC 610 □ SAGE □ UWOFA □ UWOPA

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: _____ Day/Month/Year **Time:** _____ a.m/p.m

Date & Time AII Reported: _____ Day/Month/Year **Time:** _____ a.m/p.m.

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

Employee Return to Work Date: _____ a.m./p.m.
Day/Month/Year/Time

Normal Working Hours & Days:

	Sun	Mon	Tue	Wed	Thu	Fri	Sat
Time							
Hours							

PART E

Contributing Factors (Check √ applicable factors):

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

_____

Detail Factors: _____

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

**** Supervisor to provide a detailed Action Plan below****

ACTION PLAN

Action Plan(include what, why & how recommendations are made)	**Party Responsible**	**Completed Date**	**Follow Up**

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:

		Initial - Sent Off:
Distribute copies to: ***(Supervisor to do)***	***1) Workplace/Student Health Services (UCC 25)***	_____
	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	_____

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: _____

ADDITIONAL INFORMATION

Name: _____ **Date:** _____

Signature: _____