



Accident/Illness/Incident (AII) Reporting Form & Investigation Report

FAX COMPLETED FORM (Within 24 hours) TO: 519-661-3420 (83420)

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

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

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:

	Sun	Mon	Tue	Wed	Thu	Fri	Sat
Time							
Hours							

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

PART E

Contributing Factors (Check applicable factors):

- | | |
|---|---|
| <ul style="list-style-type: none"> <input type="checkbox"/> Hazardous method/procedure used <input type="checkbox"/> Improper position/posture (ergonomics) <input type="checkbox"/> Inadequate personal protective equipment <input type="checkbox"/> Incorrect/defective tools <input type="checkbox"/> Unsafe design or construction <input type="checkbox"/> Poor weather conditions <input type="checkbox"/> Hazardous housekeeping or arrangement <input type="checkbox"/> Inexperience of person in the task <input type="checkbox"/> Training/job instruction inadequate | <ul style="list-style-type: none"> <input type="checkbox"/> Inadequate guarding of material & equipment <input type="checkbox"/> Inadequate lighting/ventilation <input type="checkbox"/> 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

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: _____	
<i>(if applicable)</i>	Date: _____
OHS Signature: _____	
<i>(if applicable)</i>	Date: _____

****FAX COMPLETED FORM TO 519-661-3420 OR EXT 83420 (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 | _____ |
| 6) Unit/Department Health & Safety Officer | _____ |

