



Work Related Incident Form

An incident is an unplanned or unwanted event that causes harm or has the potential to cause harm. All divisional employees and volunteers are required to complete this form when injured or ill or experiencing pain as a result of carrying out work duties or to report an incident with the potential to cause serious injury/illness. For more information refer to the divisional OHS Standard 02 or contact the health and safety officer at 926-2435. If hospitalization is required, please notify human resources and the health and safety officer. Provide a copy of this completed record to the injured employee, human resources and health and safety and file a copy at the worksite in a confidential location for at least 3 years.

Person's Full Name :		School or Worksite :		Home Phone:		Room or Location of Incident:	
Date of incident (D/M/Y):		Time: AM or PM		Date reported to Supervisor (D/M/Y):		Time: AM or PM	
Who did you report the incident to?				If you did not report on same date of incident why not?			
Is this incident related to work duties? <input type="checkbox"/> Yes <input type="checkbox"/> No				Does this incident involve a work related injury or illness? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Staff Group:		Body Part Injured:			Type of Injury:		
<input type="checkbox"/> Custodial <input type="checkbox"/> Exempt <input type="checkbox"/> Maintenance <input type="checkbox"/> Support <input type="checkbox"/> Teacher <input type="checkbox"/> Other		<input type="checkbox"/> Head <input type="checkbox"/> Face <input type="checkbox"/> Teeth <input type="checkbox"/> Neck <input type="checkbox"/> Back <input type="checkbox"/> Ribs <input type="checkbox"/> Trunk <input type="checkbox"/> Fingers <input type="checkbox"/> Hand <input type="checkbox"/> Wrist <input type="checkbox"/> Arm <input type="checkbox"/> Elbow <input type="checkbox"/> Shoulder <input type="checkbox"/> Toes <input type="checkbox"/> Foot <input type="checkbox"/> Ankle <input type="checkbox"/> Leg <input type="checkbox"/> Knee <input type="checkbox"/> Hip <input type="checkbox"/> Other			<input type="checkbox"/> Chemical or Biological Exposure <input type="checkbox"/> Burn <input type="checkbox"/> Concussion <input type="checkbox"/> Cut <input type="checkbox"/> Bruise <input type="checkbox"/> Dislocation <input type="checkbox"/> Fracture <input type="checkbox"/> Puncture <input type="checkbox"/> Repetitive Motion <input type="checkbox"/> Scrape <input type="checkbox"/> Sprain/Strain <input type="checkbox"/> Other		
Description of incident, injury or illness and how it occurred.							
This section to be completed by the employee and their supervisor.							
Incident Type: <input type="checkbox"/> Minor First Aid <input type="checkbox"/> Health Aid <input type="checkbox"/> Lost Time from Work <input type="checkbox"/> No Lost Time <input type="checkbox"/> Other							
Was first aid given? <input type="checkbox"/> Yes <input type="checkbox"/> No		Name of First Aider:					
Qualifications of First Aider: <input type="checkbox"/> Emergency First Aid <input type="checkbox"/> Standard First Aid <input type="checkbox"/> Nurse <input type="checkbox"/> Other							
Describe first aid provided :							
Has the employee seen a doctor or other health care professional?						<input type="checkbox"/> Yes <input type="checkbox"/> No	
Is injury likely to result in time away from work or require health treatment beyond the day of the injury?						<input type="checkbox"/> Yes <input type="checkbox"/> No	
If yes and the employee is covered by WCB, has the <i>WCB Employer's and Worker's Report of Injury</i> been completed and faxed to human resources? If not, please complete and fax along with this record form within 24 hours of the incident (Fax: (780) 927- 4625).						<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A	
If there is time lost from work beyond the day of the incident, what was the first day off work? (D/M/Y)							
Has a copy of this <i>Record</i> been faxed to human resources and health and safety? If not please fax within 24 hours of the incident (Fax # (780)927-4625 and (780) 926-3037).						<input type="checkbox"/> Yes <input type="checkbox"/> No	
What was the cause of the incident, injury or illness?							
What can be to done to prevent a similar incident in the future?							
Did this incident result in hospitalization, a serious injury/illness or have the potential to result in serious injury/illness? If yes, conduct a full incident investigation using the divisional <i>Incident Investigation Report</i> form.						<input type="checkbox"/> Yes <input type="checkbox"/> No	
Employee's Name (Print):				Signature:		Date (D/M/Y):	
Supervisor's Name (Print):				Signature:		Date (D/M/Y):	