## Incident Report

All first aid, health care and lost time incidents that are worklated are required to be reported by law.

If this is a Critical Injury, call ERC6att3-533-6111 or 911 immediately.

Arrange first aid treatment or health care if needed.

Lost time begins once employee is absent or unable to work on any day after the incident due to work related injury.

A. W Œ ∮ ŷ À } o ÀŒjured Information

Role at time of Incident/Injury: Employee Student-Staf ( Unpaid Student Visitor

Type of Acc	ident/Illnes <b>£</b> lea	se chec	ck all that apply				
Struck/Caught Overexertion Repetition Slip/Trip		Fall from Harmful Animal	nheight Substances/Environn	A: Fi	otor Vehicle Incident ssault re/Explosion (\$\frac{1}{2}X \times \frac{1}{2}X \times \f		
						Upper Back Lower Back Abdomen Pelvis Other X X X X X X X X X X X X	
C. Investigat	ion / Corrective	Action	THIS SECTION TO BE C	OMPLETED BY SUPER	/ISOR		
µ y <b>y</b>	\$ <b>}</b> } <b>}</b> \$V	d <b>Ø</b>	<b>₩</b> U <b>I</b> bo <b>&amp;</b> Ç			·	
Unsafe equipment or tools Unsafe loading, lifting, placing Hazardous method/procedure No identified procedure or lackof SOP Inadequate training Fire, explosion, atmospheric hazar			Failure to use personal protective equipment / used incorrect PPE Unsafe posture, position, ergonomics Failure to follow established procedures Lack of experience, skill of person performing task or using equipment Hazardous housekeeping Personal medical condition		Hazardous workspace/ facility Hazardous personal attire Hazardous condition, weather Repetitive action Sharps-related Other t please explain:		

Have you determined the root cause of incident? ☐ Yes No

₩esYesYes

D. Health Care , கூற்கைம்ற்க்}			V	M z•E}						
When did I Á ]theoperson receive health cainjury (DD/MM/YY)?	When did the supervisor learn that the person received health care (DD/MM/YY)?									
Where was the person treated for this injur	ry? (Please che	ck all that apply)								
☐ Ambulance Emergency department	nitted to hospital									
Walsh & Assoc. Occupational Health Name, address and	□ OtherX									
XXXXXXXX XXXXXXX										
Are you aware of any prior or related problems, injury or conditions? Yes No										
Have you received work limitations/ restrictions for this injury? Yes □ No	Has modified work been offered to this worker? Yes No			Has modified work been accepted by this worker? Yes No						
E. Lost Time										
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The next day/shift after the accident, did the person ~ Á ] š µ v š] o v Æ š Ç: (} Œ š Z] • ‹µ • š]} v Return to regular work Return to modified work Lose work time and/or earnings										
This lost time information was confirmed b	y (Name, Posit	ion, Telephone):								
Complete following questions only if th	ere was lost t	ime from work a	fter day of	incident						
Date and time last worked (DD/MM/YY): AM □PM	Normal working Start	ng hours on day of _ AM P¹ _ AM □ P¹	VI	pected date of re	eturn (DD	/MM/YY):				

The personal information on this form is collected under the authority of the Royal Charter of 1841, as amended. If you have any questions or concerns about the information collected or how it will be used, please contact the Department of Environmental Health and Safety by telephone at 613-533-2999.