



EMPLOYEE INCIDENT FORM (This information is to be used for completion of WSIB form 7)

Employee Information	Last Name: First Name: Date of Birth:	Primary Telephone #: Work Telephone #: Employee ID: SIN:
	Address: City/Town: Province: Postal Code:	
	Division/Dept/Unit: Occupational at Time of injury:	Employment Status <input type="checkbox"/> Full-time <input type="checkbox"/> Casual <input type="checkbox"/> Part-time <input type="checkbox"/> Student
Description of incident	Date of incident: Time of incident day: AM/PM Date reported: Time of reporting day AM/PM	To whom was the incident reported? If the report is delayed, please explain why:
	State the exact sequence of events leading up to the incident. Include an explanation of what the employee was doing : What caused the injury/illness?	Did the incident happen on the employer's premises or the workplace? <input type="checkbox"/> Yes <input type="checkbox"/> No Identify the sizes, weights & types of equipment involved: Type of incident (check one- see instructions for definitions) <ol style="list-style-type: none"> 1. <input type="checkbox"/> Struck/Caught 2. <input type="checkbox"/> Overexertion 3. <input type="checkbox"/> Repetition 4. <input type="checkbox"/> Fire/Explosion 5. <input type="checkbox"/> Fall 6. <input type="checkbox"/> Harmful Substance/Environmental 7. <input type="checkbox"/> Workplace violence 8. <input type="checkbox"/> Workplace Harassment 9. <input type="checkbox"/> Slip/ Trip 10. <input type="checkbox"/> Motor Vehicle Incident 11. <input type="checkbox"/> Heat or Cold Stress related incident 12. <input type="checkbox"/> Other



Witnesses	Name, position & phone numbers of witnesses or persons having knowledge of incident:				
	Witness Name: Position: Phone Number: Email:				
	Witness Name: Position: Phone Number: Email:				
	Witness Name: Position: Phone Number: Email:				
	Witness Name: Position: Phone Number: Email:				
Causes	Was the accident/illness: <input type="checkbox"/> Sudden, Specific event/occurrence? <input type="checkbox"/> Gradually occurring over time? <input type="checkbox"/> An Occupational Disease? <input type="checkbox"/> Fatality?				
	Direct Causes (Check one-see instructions): <input type="checkbox"/> Physical/Environmental <input type="checkbox"/> Personal Basic causes (check one): <input type="checkbox"/> Job Factors <input type="checkbox"/> Personal factors				
Correction	Action(s) Taken:	Corrected <input type="checkbox"/>	Planned <input type="checkbox"/>	Date	Example of actions: 1. Training of person involved 2. Reassignment of person 3. Order job safety analysis 4. Improve personal protective equipment 5. Action to improve inspection 6. Equipment repair or replacement 7. Correction of congested area 8. Installation of guard or safety device 9. Actions to improve design/procedure 10. Check with manufacturer 11. Inform all department supervisors and management 12. Disciplinary action, if required 13. Other preventative and damage control actions
		<input type="checkbox"/>	<input type="checkbox"/>		
		<input type="checkbox"/>	<input type="checkbox"/>		
		<input type="checkbox"/>	<input type="checkbox"/>		
		<input type="checkbox"/>	<input type="checkbox"/>		
Injury	Describe the illness or injury, part of body involved and specify left or ride side.				
	Are you aware of any prior similar or related problem, injury, or condition? Please specify and explain				
	If there was no injury was this a hazardous situation or near miss? <input type="checkbox"/> Yes <input type="checkbox"/> No				
	Injury- No WSIB Claim: <input type="checkbox"/> First Aid <input type="checkbox"/> No Aid WSIB Claim treatment memorandum: <input type="checkbox"/> Health care (medical aid) <input type="checkbox"/> Lost time				
Occupational Health	Did employee seek medical attention? (check one) <input type="checkbox"/> Yes <input type="checkbox"/> No				
	Did employee visit health service? (check one) <input type="checkbox"/> Yes <input type="checkbox"/> No				
	Did employee visit emergency? (check one) <input type="checkbox"/> Yes <input type="checkbox"/> No				
	If Yes, ER physician's name: Physician's / Health unit Tel. # :				



	<p>Will the employee perform: <input type="checkbox"/> Regular duties <input type="checkbox"/> Modified duties <input type="checkbox"/> Remain off work</p> <p>Has the employee had a similar disability? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown</p> <p>Check attachments to this report: <input type="checkbox"/> Statements <input type="checkbox"/> Photographs <input type="checkbox"/> Treatment memo <input type="checkbox"/> Other- specify</p> <p>_____</p>
<p>Signature (Note Date will be added when signed electronically)</p>	<p>Employee Signature:</p> <div style="border: 1px solid black; height: 40px; width: 500px; margin-bottom: 10px;"></div> <p style="text-align: center; font-size: 2em; margin-bottom: 10px;">X</p> <p style="text-align: right; margin-bottom: 10px;">Date: _____</p> <p>Manager Signature:</p> <div style="border: 1px solid black; height: 40px; width: 500px; margin-bottom: 10px;"></div> <p style="text-align: center; font-size: 2em; margin-bottom: 10px;">X</p> <p style="text-align: right; margin-bottom: 10px;">Date: _____</p> <p>Occ. Health Department Signature:</p> <div style="border: 1px solid black; height: 40px; width: 500px; margin-bottom: 10px;"></div> <p style="text-align: center; font-size: 2em; margin-bottom: 10px;">X</p> <p style="text-align: right; margin-bottom: 10px;">Date: _____</p>



INSTRUCTIONS FOR COMPLETION OF EMPLOYEE INCIDENT FORM

The purpose of this report is to:

- Collect factual data relating to the occurrence of a workplace injury
- Collect data for completion of the WSIB report, form 7.
- Provide a systematic means to record incidents, document the results of investigations and note how, when and what corrective action will be taken
- Help to ensure the provision of prompt medical treatment
- Assist in the determination of the causative factors related to the incident
- Systematically collect factual data for statistical records
- Guide the investigator in conducting an effective investigation

NOTE: Shaded information in the form is considered confidential and should not be shared with the joint health and safety committee.

ORIGINAL to be kept in "Employee Incident Report" file in H&S area/ division

2ND COPY to injured worker's supervisor

3RD COPY to injured worker's occupational health or employee file

TYPE OF INCIDENTS – DEFINITIONS

Struck/Caught

- An incident in which a person has been struck abruptly or forcefully by some object in motion (e.g., box falls off shelf, employee jabs needle into finger, person pushing cart runs into someone) or a person is contacted non-forcefully by some substance or agent in motion that has an injury upon contact characteristic (such as being splashed by hot or corrosive solutions).
- An incident in which a person strikes abruptly or forcefully some stationary object in his/her surroundings (e.g., nurse strikes his/her leg against the crank of a bed) or comes into contact, non-forcefully, with some stationary substance or agent that has an injury-upon-contact characteristic (such as electrical shock).
- An incident in which a person is:
 - a) Trapped in some type of enclosure or a part of a person's body is caught in some type of opening (e.g., a person is caught in an elevator or locked into a refrigerated room)
 - b) Caught on some protruding object (e.g., a person's clothing gets hooked onto a handle or a person catches his/her hand on a sharp edge)
 - c) Pinched, crushed or otherwise caught between either a moving object and a stationary object or between two or more moving objectives (e.g., a person jams his/her fingers between a wheeled cart and doorway).

Fall

A fall on the same level on which a person was standing or walking, or when a person falls to below the level on which he/she was standing or walking.

Slip/Trip

The person either slips or trips but does not fall.

Overexertion

An incident is one in which a person puts excessive strain on some part of his/her body (e.g., an employee strains his/her back or some other part of the body).



Harmful Substances/Environmental

An incident in which the employee is exposed to harmful conditions (e.g., toxic gases, fumes or vapours; toxic airborne particles; extremes of heat or cold; oxygen deficient atmospheres; radioactive radiation; intense light brightness, infectious diseases, blood/blood-stained body fluids, moulds/spores).

Workplace Violence

- The exercise of physical force by a person against a worker, in a workplace, that causes or could cause physical injury to the worker,
- An attempt to exercise physical force against a worker, in a workplace, that could cause physical injury to the worker.
- A statement or behaviour that it is reasonable for a worker to interpret as a threat to exercise physical force against the worker, in a workplace, that could cause physical injury to the worker.

Workplace Harassment

- Engaging in a course of vexatious comment or conduct against a worker in a workplace that is known or ought reasonably to be known to be unwelcome, or
- Workplace sexual harassment

Workplace Sexual Harassment

- Engaging in a course of vexatious comment or conduct against a worker in a workplace because of sex, sexual orientation, gender identity or gender expression, where the course of comment or conduct is known or ought reasonably to be known to be unwelcome, or
- Making a sexual solicitation or advance where the person making the solicitation or advance is in a position to confer, grant or deny a benefit or advancement to the worker and the person knows or ought reasonably to know that the solicitation or advance is unwelcome

Repetition

An incident that develops over a period of time due to the repetitive nature of the task being carried out (e.g., pipetting, keyboarding).

Fire/Explosion

An incident in which the employee is subjected to a fire or explosion in the workplace.

Motor Vehicle Incidents

An incident in which the employee is involved in a motor vehicle incident during the course of his/her work activities.

DIRECT CAUSES - DEFINITIONS

Physical/Environmental

Contributing conditions such as machinery/equipment, housekeeping, physical agents, chemical agents, personal protective equipment, temperature (heat/cold), etc.

Personal

Contributing actions such as unauthorized equipment use, improper body motion, working at unsafe speeds.

BASIC CAUSES

Job Factors

Work procedures, purchasing, design, training, engineering controls, etc.



Safe Environments
Healthy Workers

www.pshsa.ca

Personal Factors

Physical restrictions, lack of training, motivation, inadequate capability, etc.