Injury/Near Miss and Incident Reporting Investigation Form

Work Related Injury and/or Near Miss Form

Section I – To be completed by EMPLOYEE and submitted immediately following incident.
Section II & III – To be completed by EMPLOYEE and PRINCIPAL
Section IV – To be completed by PRINCIPAL.

If the employee is too injured to complete any of the sections, the Workplace Safety and Health Co-chair will be involved to help investigate the Incident.

Distribution

1. Before the end of the day fax copy of report to the Business office clerk for reporting to WCB (Payroll)
2. Keep original for continued follow-up to resolution and for final filing in staff file.

When preventive / corrective actions have been completed, signatures added and send report to: Park West Health and Safety Officer

WCB Reporting Requirements – all staff excluding teachers

Workers Compensation Board (WCB)
Employers must report any work-related injury/illness that involves time loss from work and/or a need for medical attention to the WCB. Employers must report the incident within five (5) working days of the incident or within five (5) working days of when they first learn of the incident. WCB charges late fees for reports that are delayed longer than 5 days post-injury. Employers must ensure that the injured/ill worker is given a benefits package if the worker requires medical attention or misses time from work as a result of the work-related injury/illness.

✓ *This applies to Support Staff only as Teachers are not covered by WCB, Reported to WCB* ☐ **Yes** ☐ **No**

SERIOUS INCIDENT REPORT REQUIREMENTS – WHERE APPLICABLE

Workplace Safety and Health Division Labour and Immigration.
Serious injuries must be reported to Workplace Safety and Health at **945-0581 or toll free (1-866-888-8186).** The Workplace Safety and Health Division considers an accident to be serious if it results in serious injury (worker is killed, injury resulting from electrical contact, unconsciousness as the result of a concussion, a fracture of his or her skull, spine, pelvis, arm, leg, hand or foot, amputation of an arm, leg, hand, foot, finger or toe, third degree burns, permanent or temporary loss of sight, a cut or laceration that requires medical treatment at a hospital as defined in the health services insurance act, or asphyxiation or poisoning. The Safety Division also considers the event a serious incident if the event involves; the collapse or structural failure of a building, structure, crane, hoist, lift, temporary support system or excavation, an explosion, fire, or flood, an uncontrolled spill or escape of a hazardous substance, or the failure of an atmosphere-supplying respirator).

1. Reported to Provincial WS&H Division: ☐ **Yes** ☐ **No (does not meet requirement).**

2. If Yes: Name of Workplace Safety & Health Officer contacted: _____

Name of person who contacted WS&H Division: _____ Date: _____

3. Reported to the Workplace Safety & Health Committee Representative: ☐ Yes Date: _____

WORK RELATED INJURY / NEAR MISS FORM

SECTION I: INJURY / NEAR MISS DETAILS:
To be completed by Employee * PLEASE PRINT CLEARLY *****

1. Last Name: _____ 2. First Name: _____

3. Gender: ☐ Male ☐ Female ☐ Other ☐ Prefer not to say

5. Phone-work: _____ 6. Phone-home: _____

7. Job Title: _____ ☐ Near Miss

☐ Accident Injury

8. School/Department: _____

9. Principal/Supervisor: _____ 10. Phone: _____

11.Date of Incident: _____ 12. Time of Incident: _____

13.Date Reported: _____14. Time Reported: _____

Reported to in-charge person (name): _____Job Title: _____

Description of how injury/near miss occurred: Please give a detailed description of how the incident occurred. ***PLEASE PRINT CLEARLY***

Activity: What was your task or duty at the time the injury/near miss occurred (eg, walking, carrying, etc)?

Was the task or duty being performed at the time the injury/near miss occurred a task or duty that you regularly perform?
☐ No ☐ Yes

Type of injury:

Medical Action Taken:

Location: Where did the injury/near miss occur (Please be specific and include building, room name, floor, location details, area etc)

When the following occurred: *Detail Description of Incident.*

Witness: ☐ no ☐ yes Name of Witness: _____

SECTION II: CORRECTIVE MEASURE PLAN OF ACTION. To be completed by the Workplace Safety and Health Representative or Co-Chair, Employee, and Principal to work together and determine a suggested preventive/corrective action.

Corrective Action	*Provide details of suggested corrective action*
☐ Consult with Safety and Health	
☐ Repair/Replace Equipment	
☐ Employee Training/Education	
☐ Revise Procedures (includes PPE)	
☐ Implement Good Housekeeping Principles	
☐ Improve Design	
☐ Install guards, safety devices, signage	
☐ Other	

SECTION III: To be completed by Principal

Comments / Discussion / Notes

Signature of Principal: Date:

SECTION IV: COMPLETED PLAN OF ACTION

To be completed by Principal when preventive/corrective measures have been implemented and completed. If more space is required, please attach another page.

Corrective Action 1			
Target Date:	Person Assigned:	Date Completed:	Supervisor Initial:
Corrective Action 2			
Target Date:	Person Assigned:	Date Completed:	Supervisor Initial:
Corrective Action 3			
Target Date:	Person Assigned:	Date Completed:	Supervisor Initial:
Corrective Action 4			
Target Date:	Person Assigned:	Date Completed:	Supervisor Initial

COMMUNICATION OF CONTROL MEASURES/PROCEDURES TO EMPLOYEES	
All control measures and procedures which have been implemented have been communicated to employees.	
Date:	By: