When possible Employee **and** Supervisor should fill out together as soon as possible or contact Human Resources (HR) for assistance. Please submit the form to HR within 3 business days of the incident.

KING'S
Western University

Accident Incident Report and Investigation Form

Section 1: To be completed by injured/ill person and Supervisor

Name of Injured/Ill Person:

Contact Telephone Number: Home: Cell:

Employee: ☐ Student: ☐ Visitor: ☐

Type: Illness☐ Accident☐ Incident☐ No Injury/Hazard☐ First Aid☐ Lost Time☐ No Lost Time☐

Section 2: To be completed by injured/ill person and Supervisor

Date and Time of Incident:

Date and Time of Report:
(If not reported on day of occurrence, specify reason)

Description of Accident/Illness/Incident: (What happened? What was the person doing? Was there any equipment, people or materials involved – identify the size, weight and type)

Where did the incident occur? Location/area (Building and Room #)

Please specify part of body injured. (Specify left or right side)

Please rate the severity of the injury/incident:

- ☐ Insignificant (No treatment, no damage, no disruption of services)
- ☐ Minor (First Aid treatment, minor damage, no disruption of services)
- ☐ Moderate (Requires medical treatment, damage to property <$1000, minimal disruption of services)
- ☐ Major (Requires emergency response medical treatment, damage to property >$1000, major disruption of services)
- ☐ Fatality (Major damage, extensive disruption of services)

Section 3: Treatment to be completed by injured/ill person and Supervisor

1. Did the employee/visitor/student receive first aid and by whom? ☐Yes ☐No

If yes give treatment details and first aider contact information:

2. Did the employee/visitor/student visit the hospital or a physician? ☐Yes ☐No

If yes please give name of hospital/physician, date and time and also method of transportation (e.g. ambulance)

3. To your knowledge, had the person had a similar injury? If YES please explain below. ☐Yes ☐No

Section 4: Investigation to be completed by injured/ill person, Supervisor and/or Human Resources

1. Is the employee off work due to the incident/injury? ☐Yes ☐No

   a) Date and hour last worked:

   b) Employee return to work date:

2. Contributing Factors: (please check all applicable factors)

- ○ Hazardous method/procedure used
- ○ Improper position/posture (ergonomics)
- ○ Inadequate personal protective equipment
- ○ Incorrect/defective tools
- ○ Unsafe design or construction
- ○ Poor weather conditions
- ○ Inexperience of person in the task
- ○ Training/job instruction inadequate
- ○ Inadequate guarding of material and equipment
- ○ Inadequate lighting/ventilation
- ○ Trips, Slips, Falls
- ○ Rushing/inattention to surroundings
- ○ Other:

3. Actions and Follow up to prevent Recurrence:

- Create a work order
- Actions to improve design/procedures
- Correct congested areas
- Repair or replace tool/equipment
- Improve personal protective equipment
- Install guard or safety device
- Reinstruct person involved and provide support/coaching
- Request ergonomic assessment
- Update training

4. Action Plan – supervisor to provide detailed action plan below:

Action Plan (include what, why and how recommendations are made) Work Order #'s

Party Responsible:

Completed Date:

Signature by Supervisor/BUH:

Date:

Employee/Visitor/Student Signature:

Date:

Section 5: Investigation:

Name of Witness(es):

Contact Information:

Phone/Ext.:

Official Account of Witness: (please attach separate document and sign the document)

Human Resources Follow up Signature:

Date:

Follow up