

Section 1: Accident/Illness/Incident Reporting Form

Part A

Name of Employee: Western ID Number:

Employee's Contact Information: Phone Number: Email:

Employee Group (*if applicable*):

- UWOSA PMA CUPE 2361 CUPE 2692 IUOE SAGE UWOFA UWOFA-LA OPSEU
 PostDoc Assoc PSAC 610

Status: RF RP/TF TP Undergrad Student Grad Student Other/Visitor

Type: Occ. Illness Accident Incident No Injury/Hazard First Aid Health Care Lost time No Lost Time

Part B

Date of Accident/Illness/Incident: Time of Accident/Illness/Incident: am pm

Date Reported: Time Reported: am pm

Reason for Report (**Check all that apply**):

- | | | | |
|---|--|---|---|
| <input type="checkbox"/> Abrasion/Contusion | <input type="checkbox"/> Cut/Laceration | <input type="checkbox"/> Heat Stress | <input type="checkbox"/> Psychological |
| <input type="checkbox"/> Allergic Reaction | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Medical Symptoms | <input type="checkbox"/> Slip/Trip/Fall |
| <input type="checkbox"/> Animal/Insect Bite | <input type="checkbox"/> Fire/Explosion | <input type="checkbox"/> Loss of Consciousness | <input type="checkbox"/> Sprain/Strain |
| <input type="checkbox"/> Blood/Body Fluid Exposure | <input type="checkbox"/> Fracture | <input type="checkbox"/> Motor Vehicle Accident | <input type="checkbox"/> Struck by/Struck against |
| <input type="checkbox"/> Burn | <input type="checkbox"/> Hazardous Substance | <input type="checkbox"/> Needle Stick | <input type="checkbox"/> Violence/Harassment |
| <input type="checkbox"/> Other (if "other" explain – be specific) | | | |

Description: In the box below, provide a 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?).

Specify Body Part (e.g., left or right side):

In the box below, please provide the location/area of the Accident/Illness/Incident or hazardous situation (Building, room number, floor, level, inside/outside – be specific).

Location:

Part C

Treatment of Injury:

1. Did the Employee/Student receive First Aid? Yes No If yes, by whom?
Provide treatment details:
2. Did the Employee/Student visit Workplace Health/Student Health? Yes No
3. Did the Employee/Student visit Hospital and/or Physician? Yes No
If yes, provide details in the box below (i.e., hospital/physician, address, date &time, phone number, transportation details).
Hospital/Physician Information:
4. To your knowledge, has the person had a similar illness/injury? Yes No
If yes, please explain:

Part D

Is the Employee off work due to this Accident/Illness/Incident? Yes No

Date Last Worked: Hour Last Worked: am pm

Return to Work Date:

If the **Employee works a regular schedule**, please provide:

	Sun	Mon	Tue	Wed	Thu	Fri	Sat
Start/End Time	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Hours/Shift	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

If the **Employee works a repeating rotational shift**, please provide:

Number of days on: Number of days off: Hours per shift: Number of weeks in cycle:

If the **Employee works a varied or irregular work schedule**, please check this box

Was modified work discussed with the employee? Yes No

Was modified work offered to the employee? Yes No

If yes, was it accepted or declined?

Describe the type of modified work offered (be specific):

Section 2. Investigation Report

Immediately investigate if any of the following occur:

Fatalities, Critical Injuries, Lost Time, Occupational Illness, Property Damage, Fire or Environmental Release.

Part E

Contributing Factors (Check all that apply)

- | | |
|---|---|
| <input type="checkbox"/> Did not Understand the Work/Task Instructions | <input type="checkbox"/> Lack of Training/Information/Instruction about PPE |
| <input type="checkbox"/> Excessive Noise | <input type="checkbox"/> Lack of Training/Information of Supervisors |
| <input type="checkbox"/> Failure of Material/Equipment | <input type="checkbox"/> Not Guarded/Inadequately Guarded |
| <input type="checkbox"/> Failure to Detect/Correct Known Hazard(s) | <input type="checkbox"/> Not Wearing proper PPE |
| <input type="checkbox"/> Failure to Implement Recommendations from JHSC | <input type="checkbox"/> Poor Housekeeping/Hazardous Arrangement |
| <input type="checkbox"/> Failure to Secure/Warn | <input type="checkbox"/> Poor Weather Conditions |
| <input type="checkbox"/> Hazardous Method/Procedure Used | <input type="checkbox"/> Slippery, Dusty or Untidy Surfaces |
| <input type="checkbox"/> Improper Position/Posture (Ergonomics) | <input type="checkbox"/> Training/Job Instruction Inadequate |
| <input type="checkbox"/> Inadequate Enforcement of Safety Rules | <input type="checkbox"/> Unauthorized Task/Operation |
| <input type="checkbox"/> Inadequate Personal Protective Equipment | <input type="checkbox"/> Unsafe Design/Construction |
| <input type="checkbox"/> Incorrect/Defective/Unavailable Tool(s) | <input type="checkbox"/> Workstation Layout is Faulty |
| <input type="checkbox"/> Inexperience of Person in the Task | <input type="checkbox"/> Other (specify in box below – be specific) |

Actions and Follow Up to Prevent Recurrence (Check all that apply):

- | | |
|--|---|
| <input type="checkbox"/> Actions to Improve Design/Procedures | <input type="checkbox"/> Obtain Proper Tool/Equipment |
| <input type="checkbox"/> Contact Facilities Management for Assistance | <input type="checkbox"/> Order Job Safety Analysis to Completed |
| <input type="checkbox"/> Contact Occupational Health & Safety for Assistance | <input type="checkbox"/> Refer to Employee Well-being |
| <input type="checkbox"/> Correct Congested Area | <input type="checkbox"/> Reinstruct Person Involved and/or Provide Coaching |
| <input type="checkbox"/> Improve Personal Protective Equipment | <input type="checkbox"/> Repair/Replace Tool/Equipment |
| <input type="checkbox"/> Improve Preventive Maintenance Program | <input type="checkbox"/> Request Ergonomic Assessment |
| <input type="checkbox"/> Install Guard or Safety Device | <input type="checkbox"/> Update Training |
| <input type="checkbox"/> Other (specify in box below – be specific) | |

Action Plan: Supervisor to provide a detailed Action Plan

Action Plan (include what, why & how recommendations are made):	Party Responsible	Completed Date	Follow Up

Part F

Investigated by:

Name of Supervisor: Telephone Number:

Supervisor Signature:

Reviewed by:

Department Chair/Unit Head Signature: Date:

Employee Signature: Date:

Email completed form (**within 24 hours**) to uwoair@uwo.ca or fax to 519-661-3420 (83420)

Part G

Supervisor to distribute copies to:

- Budget Unit Head/ Chair/ Supervisor
- Employee/Student/Visitor
- Originator of AIIR
- Unit/Department Health & Safety Officer
- Applicable Employee's Union/Staff Group- JOHSC Rep
 - UWOSA (info@uwosa.ca) PMA (gdhami2@uwo.ca) CUPE 2361 (dstanley@uwo.ca)
 - CUPE 2692 (spaiva@uwo.ca) OPSEU (jvanhaar@uwo.ca) IUOE (lpellar2@uwo.ca)
 - SAGE – (amy.vandamme@uwo.ca) UWOFA (peter.chidiac@schulich.uwo.ca)
 - UWOFA-LA- (peter.chidiac@schulich.uwo.ca) PSAC 610/Post Doc (johsc.psac610@gmail.com)

Witness Statement (include for each witness when submitting AIIR)

Name of Witness and phone number:

Date and Time of Accident/Incident:

Injured Worker's Name:

Location of Accident/Incident:

Your Account of the Accident/Incident:

Signature of Witness:

Date: