POLICY: ACCIDENT / ILLNESS / INCIDENT REPORTS			NUMBER: S-11
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PREPARED BY: Facilities Management (FM)	AUTHORIZED BY  Andrew Konowalchuk	CLASSIFICATION: Safety Procedure	EFFECTIVE: April 24, 2023
			SUPERSEDES: July 1, 2015

An Accident/Illness/Incident Reporting Form & Investigation Report (AIIR) must be completed by supervisors whose employees were involved in an accident or incident during working hours. The

Accident/Incident/ , O O Q H V V $, Reporting Form & Investigation Report

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SECTION #1 – Accident/Incident/ , O O Q H V V Reporting Form

PART A

Name of Employee: ______________________________ Employee Number: ____________________

Contact Telephone Number of Employee: (Home)____________________ (Cell)____________________

Employee Group (if applicable): ‘ UWOSA ‘ PMA ‘ CUPE 2361 ‘ CUPE 2692 ‘ IUOE ‘ PSAC 610 ‘ SAGE ‘ UWOFA ‘ UWOPA

Status: ‘RF ‘RP/TM ‘CW ‘Undergrad Student ‘Grad Student ‘Other/Visitor

Type: ‘ 2 F F , O O Q H V V ‘Accident ‘Incident ‘No Injury/Hazard ‘ First Aid ‘ Lost Time ‘ Non-Lost Time

PART B

Date & Time of A ™` What was the person doing? Was there any Time: __________ a.m/p.m

Day/Month/Year

als involved- identify the size, weight and type)

____

Name & Contact Information of Witness(es):____

(If there are witnesses, please include a statement from each witness)

PART C

Treatment of Injury:

1. Did the Employee/Student receive First Aid and by whom? YES ‘ NO ‘

If YES, give treatment details:____

2. Did the Employee/Student visit Workplace/Student Health? YES ‘ NO ‘

3. Did the Employee visit Hospital and/or Physician? YES ‘ NO ‘

If YES, what hospital/physician, date & time, address, phone number & give transportation details (e.g. ambulance):

____

To your knowledge, has the person had a similar disability? If YES, please explain below YES ‘ NO ‘

____

SECTION #2 – Investigation Report

PART D

Immediately investigate if any of the following occur: Fatalities, Critical Injuries, Lost Time, Occupational Illnesses, Property Damage, Fire or Environmental Release

Is the employee off work due to this$, ,? ‘ Yes ‘ No

Date & Hour Last Worked: _____ a.m./p.m.

PART F

INVESTIGATED BY:

Name of Supervisor: _____

WITNESS STATEMENT (Include for each witness when submitting AIIR)

Name of Witness: _____

Contact Information: _____

Phone/Ext: _____

Date and Time of Accident/Incident: _____

Injured Worker's N ame: _____

Location of Accident/Incident: _____

Your Account of the Accident/Incident:

Name of Witness: _____ Date: _____

Signature of Witness: _____

ADDITIONAL INFORMATION

Name: _____ Date: _____

Signature: _____