



INCIDENT REPORT & INVESTIGATION FORM

Section 1 – Affected Individual’s Information

Please PRINT

First Name and Last Name		SIN <small>(student on placement or employee only)</small>	Date of Birth dd / mm / yyyy				
Home Address <small>(include street number, street name, apt no.(if applicable), city, province and postal code)</small>			Home Telephone / Cell Phone Number		Work Extension		
Occupation and Department at College <i>(Employee)</i>		Age	Gender M <input type="checkbox"/> F <input type="checkbox"/>	Employee <input type="checkbox"/>	Student <input type="checkbox"/>	Public <input type="checkbox"/>	Contractor <input type="checkbox"/>
Student ID OR Employee ID Number	Program at College <i>(Student)</i>			Reason on Campus <i>(public or contractor)</i>			

Section 2 – Incident Information

Location of Incident <i>(Campus or Off-site Location, Room #, Staircase location, Parking Lot information)</i>		Date of Incident dd / mm / yyyy	Time of Incident hh:mm <input type="checkbox"/> AM <input type="checkbox"/> PM							
Was the accident / illness:		Type of incident <i>(Please check all that apply)</i>								
<input type="checkbox"/> Sudden Specific Event/Occurrence		<input type="checkbox"/> Laceration/Cut	<input type="checkbox"/> Slip or Fall		<input type="checkbox"/> Bruise					
<input type="checkbox"/> Gradually Occurring Over Time		<input type="checkbox"/> Overexertion <small>(strain/sprain)</small>	<input type="checkbox"/> Harmful Substance/Environmental		<input type="checkbox"/> Motor Vehicle Incident					
<input type="checkbox"/> Occupational Disease		<input type="checkbox"/> Repetitive Injury	<input type="checkbox"/> Assault		<input type="checkbox"/> Needle Stick					
		<input type="checkbox"/> Burn	<input type="checkbox"/> Other		<input type="checkbox"/> Bodily Fluid Splash					
Area of Injury - Please check all that apply:										
<input type="checkbox"/> Head	<input type="checkbox"/> Teeth	<input type="checkbox"/> Upper back	Left <input type="checkbox"/> Shoulder	Right <input type="checkbox"/>	Left <input type="checkbox"/> Wrist	Right <input type="checkbox"/>	Left <input type="checkbox"/> Hip	Right <input type="checkbox"/>	Left <input type="checkbox"/> Ankle	Right <input type="checkbox"/>
<input type="checkbox"/> Face	<input type="checkbox"/> Neck	<input type="checkbox"/> Lower back	<input type="checkbox"/> Arm	<input type="checkbox"/>	<input type="checkbox"/> Hand	<input type="checkbox"/>	<input type="checkbox"/> Thigh	<input type="checkbox"/>	<input type="checkbox"/> Foot	<input type="checkbox"/>
<input type="checkbox"/> Eye(s)	<input type="checkbox"/> Chest	<input type="checkbox"/> Abdomen	<input type="checkbox"/> Elbow	<input type="checkbox"/>	<input type="checkbox"/> Finger(s)	<input type="checkbox"/>	<input type="checkbox"/> Knee	<input type="checkbox"/>	<input type="checkbox"/> Toe(s)	<input type="checkbox"/>
<input type="checkbox"/> Ear(s)		<input type="checkbox"/> Pelvis	<input type="checkbox"/> Forearm	<input type="checkbox"/>			<input type="checkbox"/> Lower Leg	<input type="checkbox"/>		
<input type="checkbox"/> Other										

Section 2 - Incident Information Continued

Description of Incident *(Describe what happened to cause the incident and what the worker/student was doing at the time. Detail what the injury is and any other contributing factors to the incident.)*

Type of Care Provided:			
First Aid at College Health Center	<input type="checkbox"/>	Health Care College Health Care Center	<input type="checkbox"/>
First Aid by Dept. First Aid Delegate	<input type="checkbox"/>	Health Care at Clinic Clinic Information	<input type="checkbox"/>
First Aid by Security	<input type="checkbox"/>	Health Care at Hospital Hospital Information	<input type="checkbox"/>
First Aid by Other Specify Other	<input type="checkbox"/>	Health Care at Practitioner's Office Practitioner's Name and Phone Number	<input type="checkbox"/>
		EMS Called	<input type="checkbox"/>
		4911 or 3911 Activated	<input type="checkbox"/>
		Near Miss	<input type="checkbox"/>
		WSIB Reportable	<input type="checkbox"/>
		Critical Injury	<input type="checkbox"/>

Section 3 – Reporting Individual's Information

Name of Person The Incident Was Reported To:		Home Telephone / Cell Phone Number		Work Number	
Occupation and Department at College				Manager / Chair of Area	
Reported to College Personnel <i>(if significantly different from time incident occurred, please provide explanation)</i>			Witness information		
Date		Time		Name of Witness	
dd / mm / yyyy		hh:mm			
		<input type="checkbox"/> AM <input type="checkbox"/> PM			

Section 4 – Incident Investigation

Root Cause – What substandard actions and conditions caused or could cause the event? Were there any contributing factors?	
Witness Accounts	
Name of Witness	Witness Account <i>(if more room is required, please attach a separate piece of paper)</i>
Have there been prior similar incidents? Yes <input type="checkbox"/> No <input type="checkbox"/>	

Immediate Steps Taken To Prevent A Recurrence	Person Responsible	Date Completed
1.		
2.		
3.		
Further Action Recommended <i>(Complete an Incident Recommendation Follow-up Form)</i>	Person Responsible	Timeline for Completion
1.		
2.		
3.		

Section 5 – Authorization

Signature of Injured Person (if possible)	Print Name	Date:	Day	Month	Year
Signature of Incident Investigator (Faculty/ Manager/ Security/ OHS)	Print Name	Date:	Day	Month	Year
Signature of Manager or Chair of School (if not the Investigator)	Print Name	Date:	Day	Month	Year
Signature of Occupational Health and Safety Designate	Print Name	Date:	Day	Month	Year

Email, fax or send to Safety, Security & Facilities Management Department within 24 hours.

Tel: 519-972-2727 ext. 4303 or 4569

Fax: 519-972-2752

Jeff McEwan: jmcewan@stclaircollege.ca

Naz Binck: nbinck@stclaircollege.ca

SECURITY (evenings & weekends):

Email: securitysouth@stclaircollege.ca

PLEASE NOTE: The information on this Incident Report Form may be provided to the College's Insurance Carrier.
If you would like a copy of this incident report, please contact the Safety, Security & Facilities Management Department.