Environmental Health & Safety

Injury (Accident) / Incident/ Illness/ Hazard Report

Submit to: Environmental Health & Safety Office
Via internal mail to GM-1100-50 or Fax to Ext. 2807

***By submitting this form, you are authorizing Environmental Health and Safety to distribute the information in this form to the appropriate parties which could include the CSST.**

FOR OFFICE USE: Ref. #: _____ ❑ A ❑ I ❑ P ❑ H ❑ O

cc. Supervisor:_____ Safety Officer:_____ Union Rep.:_____
H&S Committee:_____ EHS:_____ Other:_____

▫ Injury ▫ Incident (no injury) ▫ Illness ▫ Hazard

Date of event (m/d/yy):_____ Time:_____ ▫ am ▫ pm

Brief description of event / hazard : _____

_____

If any corrective measures have been taken or are required, please explain…_____

_____

2. VICTIM OR COMPLAINANT INFORMATION:

Family Name: _____ First Name: _____ Age: _____

Home telephone: _____ Office telephone: _____

Home address: _____
No. Street Apt. # City Postal Code

Sex: ▫ Female ▫ Male

ID # : _____

Status: (At the time of event)

- ▫ Full-time Employee
- ▫ Part-time Employee
- ▫ Contract Employee
- ▫ Undergraduate Student
- ▫ Graduate Student
- ▫ External Contractor
- ▫ Visitor

Department: _____

Supervisor (if applicable): _____

Union/Association (if applicable):_____

3. EVENT LOCATION:

Campus: ▫ SGW ▫ LOY

Building: _____

Room Number: _____

Location: (Please check one, if other specify):

▫ office	▫ doorway	▫ roof
▫ classroom	▫ auditorium	▫ washroom
▫ laboratory	▫ outdoors on campus	▫ eating areas
▫ library	▫ construction site	▫ residence
▫ corridor/hallway	▫ stairs / elevator	▫ bar
▫ gym/field/ice rink	▫ parking lot	▫ other: (specify) _____
▫ loading dock	▫ outdoors off campus	
▫ boiler/mechanical room	▫ Facilities Management/ IITS shop	
▫ entire building	▫ academic workshop / studio	

4. INJURY: ▫ yes ▫ no (if no, sign and complete form)

Type of Injury: _____

Body part injured: _____

Type of treatment : ▫ None ▫ First-aid on site ▫ Health Services ▫ Family Doctor ▫ Clinic ▫ Hospital

Treatment administered by: _____ Date of treatment (m/d/yy): _____

Transportation recommended: ▫ no ▫ yes →If yes: ▫ Ambulance ▫ Taxi ▫ Car

Transportation refused: ▫ no ▫ yes →If yes, state reason: _____

Employees only: Consequence of Injury (check one):

- ▫ No First-Aid administrated, return to work
- ▫ First-Aid administrated, return to work
- ▫ Saw a physician, return to work
- ▫ Saw a physician, return to work, light duty
- ▫ Saw a physician, time loss
- ▫ Refused medical treatment

If there was time loss from work, please indicate how long: _____

Signature:_____ Date (m/d/y):_____

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If the victim is unable to complete the Injury (Accident)/ Incident /Illness /Hazard Report, the event should be reported by a witness or a supervisor.

Reported by: _____Date(m/d/yy): _____

Department: _____ Tel. : _____

Revised January 2010