Relevant sections must be completed in full by employee and supervisor. **SUBMIT WITHIN 24 HOURS** **TO**:
Health & Safety, Chrysler Hall Tower 5th Floor, Suite 500 | fax: 519-971-3671 | email: safety@uwindsor.ca

**H&S USE ONLY: INC#**

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| **SECTION A: EMPLOYEE / INJURED PERSON INFORMATION** |
| **Last Name:**      | **First Name:**      | **Telephone #:**      |
| **Status:** [ ]  Employee [ ]  Student [ ]  Volunteer [ ]  Contractor/Service Provider [ ]  Visitor [ ]  Other (Specify):        |
| **SECTION B: EMPLOYMENT DETAILS (IF NOT APPLICABLE, SKIP TO SECTION C)** |
| **Department:**      | **Occupation (Job Title):**       | **Employee #:**      |
| **Employee Group:** [ ]  Academic [ ]  Administration (Non-Union) [ ]  Union (Specify):       [ ]  Other (Specify):        |
| **Employment Type:**[ ]  Full Time [ ]  Part Time [ ]  Casual [ ]  Sessional [ ]  Temporary [ ]  Other (Specify): |
| **Employee’s Date of Hire:**      | **Date Employee Started Current Job:**      | **Rate of Pay: $**       [ ]  Hourly [ ]  Salary [ ]  Daily |
| **Weekly Pay Hours:**       | **Shift Worker:** [ ]  YES [ ]  NO **If yes, enter shift premium per hour: $**       /hr |
| **Reg. Work Hours:** | **Sun:**       | **Mon:**      | **Tues:**      | **Wed:**      | **Thurs:**      | **Fri:**       | **Sat:**       |
| **Does this schedule change week to week?** [ ]  Yes [ ]  No If yes, provide details:       |
| **SECTION C: DESCRIPTION OF THE EVENT** |
| **Date of Incident:**      | **Time of Incident:**       [ ]  AM [ ]  PM  | **Date reported:**      | **Time Reported:**        [ ]  AM [ ]  PM |
| **Name of Supervisor Reported to:**      | **Supervisor Employee #:**      | **Phone Ext:**      |
| **Exact Location of Occurrence (incl. Building & Room #):**        |
| **Was the accident/ illness:** [ ]  a sudden event [ ]  gradually occurring [ ]  occupational disease [ ]  Other:       |
| **Nature of Injury:** [ ]  Cut [ ]  Burn [ ]  Bruise [ ]  Strain/Sprain [ ]  Irritation [ ]  None [ ]  Other:       |
| **Area of Injury:** [ ] Hand [ ] Wrist [ ] Arm [ ] Foot [ ] Ankle [ ] Leg [ ]  Back [ ]  Other:       | **Side:** [ ]  Right [ ]  Left [ ]  Upper [ ]  Lower |
| **Hand Dominance:** [ ]  Right [ ]  Left  | **Emergency Response:** Did Campus Community Police respond to this incident? [ ]  Yes [ ]  No  |
| **Critical Injury:** Did the injury: result in a possible fracture, produce unconsciousness, place life in jeopardy, result in substantial loss of blood, major burns, or loss of sight? [ ]  Yes\* [ ]  No [ ]  Unsure \*Critical injuries must be reported to Campus Community Police/Health & Safety immediately. |
| **Incident Type (check one only):** [ ]  Incident Only / Near Miss [ ]  First Aid [ ]  Medical Aid / Lost Time🞟 If property damage occurred, please contact Campus Community Police for proper reporting procedures.🞟 If there was a spill during the incident, please contact the Chemical Control Centre for proper reporting procedures. |
| **If the injury requires medical aid or results in an absence from work, you must provide your Supervisor with a copy of the WSIB Form 8 (page 3) from the treating Health Professional.** |
| **Description of the incident:** *(To be filled out by Supervisor & Employee together if possible. What happened to cause the injury/incident, and what was the employee doing at the time? Include any details of equipment, materials used, and environmental conditions [work area, temperature, noise, chemicals, etc]. For a gradually occurring injury, please detail the physical activities involved with the job).*      |

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| **SECTION D: WITNESSES – Please list names of any witnesses and attach statements if available.** |
|       |
| **SECTION E: PREVENTIVE AND CORRECTIVE ACTION RESULTING FROM ACCIDENT INVESTIGATION** |
| *What action has or will be taken to prevent recurrence?* Attach additional action plans if required. |
| **#** | **Action** | **Person Responsible\*** | **Completion****Date** | **Verified by/****Date** |
| 1 |       |       |       |       |
| 2 |       |       |       |       |
| 3 |       |       |       |       |
| \*Have these items been communicated to the person responsible? [ ]  YES [ ]  NO.  |
| **Health & Safety Investigation Notes:**      |
| **SECTION F: HEALTH CARE INFORMATION** |
| **Health Care Provided by:** [ ]  Health Professional Office [ ]  Clinic [ ]  Emergency Department [ ]  Other:       |
| **Name of Health Professional who provided treatment:**      | **Date of Medical:**       | **Time of Medical:**        [ ]  AM [ ]  PM  |
| **Address:**      | **Phone # (if known):**      |
| **Absent Beyond the Date of the Accident?:** **[ ]  YES** **[ ]  NO \*Ensure page 3 of Health Professional’s Form 8 is provided to Supervisor** |
| **Date Last Worked:**       | **Hour Last Worked:**        [ ]  AM [ ]  PM  |
| If **No Lost Time**, will worker require **Modified** work? [ ]  **YES**  [ ]  **NO**  **Details:**        |
| **If there was a delay in reporting the incident, list reason(s):**      |
| **SECTION G: CLAIM INFORMATION** |
| **To your knowledge, has the worker had a previous similar injury / disease?** **[ ]  YES** **[ ]  NO***If yes, provide details and whether a similar injury was work related or not.*      |
| **Was any individual who does not work for you totally or partially responsible for the injury/disease?** [ ]  **YES**  [ ]  **NO***If yes, please explain.*      |
| **SECTION H: SIGNATURES** |
| **Completed By (Please print):**      | T**itle:**      |
| **Signature:** | **Telephone:**      | **Date:**      |
| **Department Head (Please print):**      | **Signature:** | **Date:**      |
| **Employee (Please print):**      | **Signature:** | **Date:**      |
| **SUBMIT TO** Health & Safety within 24 hours of the accident / incidentChrysler Hall Tower, 5th Floor Suite 500 | fax: 519-971-3671 | email: safety@uwindsor.ca **Originals must be sent through inter-university mail.** |