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.** | | | | | | | | | | |