

**PROGRAM CO-ORDINATOR'S INCIDENT INVESTIGATION REPORT**  
**For injuries/illnesses reported by students on unpaid work placements**

Full Name of Injured Student:	Student ID Number	Social Insurance Number:
Address of Student:	Date of Birth of Student:	
	Phone Number of Student:	
Language in which student is most fluent:		
Program of Work Experience i.e. Registered Nursing Program:		
First day of Work Experience Placement:		
Total # of months/weeks or days this student has had on this work experience:		
Date and Time of Occurrence:	Date and Time Reported:	
Person(s) to whom reported and the phone numbers of same:		
Name and Address of Placement Employer:		
Name and Phone # of Placement Employer Contact Person:		
Name and Address of Treatment Centre or Health Care Professional who provided medical aid (if applicable):		
Description of Incident which resulted in the Student's injury or illness while on the work placement. (Describe what happened, how it happened, where it happened and why it happened and list the names and addresses of any witnesses.)		

Description of incident continued:

Action taken to prevent recurrence:

To your knowledge, has the student had a previous similar injury/disease ☐ YES ☐ NO  
If yes, provide details and whether a similar injury was work related or not

Was there any lost time beyond the date of the incident as a result of the injury of illness? If so, give date and hour last worked and an estimate of how long he/she might be disabled.

Days Student is scheduled to work with Placement Employer i.e. Monday/Wednesday/Friday:

Hours scheduled to work:

Name and phone extension number of Program Co-ordinator (Please Print):

Signature of Program Co-ordinator:

Date:

Signature of Program Director:

Date: