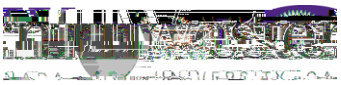

ACCIDENT/ILLNESS/INCIDENT REPORTING FORM & INVESTIGATION REPORT
Email completed form (within 24 hours) to uwoaiir@uwo.ca or fax to 519-661-3420 (83420)

Section 1: Accident/Illness/Incident Reporting Form

Part A

Name of Employee: Western ID Number:

Employee's Contact Information: Phone Number: Email:

Employee Group (if applicable):

UWOSA PMA CUPE 2361 CUPE 2692 IUOE SAGE UWOFA UWOFA LA OPSEU
PostDoc Assoc PSAC 610

Status: RF RP/TF TP Undergrad Student

Part C

Treatment of Injury:

1. Did the Employee/Student receive First Aid? Yes No If yes, by whom?
   Provide treatment details:
2. Did the Employee/Student visit Workplace Health/Student Health? Yes No
3. Did the Employee/Student visit Hospital and/or Physician? Yes No
   If yes, provide details in the box below (i.e. hospital/physician, address, date & time, phone number, transportation details).
   Hospital/Physician Information:
4.

Section 2. Investigation Report

Immediately investigate if any of the following occur:

Fatalities, Critical Injuries, Lost Time, Occupational Illness, Property Damage, Fire or Environmental Release.

Part E

Contributing Factors (Check all that apply)

Did not Understand the Work/Task Instructions	Lack of Training/Information/Instruction about PPE
Excessive Noise	Lack of Training/Information of Supervisors
Failure of Material/Equipment	Not Guarded/Inadequately Guarded
Failure to Detect/Correct Known Hazard(s)	Not Wearing proper PPE
Failure to Implement Recommendations from JHSC	Poor Housekeeping/Hazardous Arrangement
Failure to Secure/Warn	Poor Weather Conditions
Hazardous Method/Procedure Used	Slippery, Dusty or Untidy Surfaces
Improper Position/Posture (Ergonomics)	Training/Job Instruction Inadequate
Inadequate Enforcement of Safety Rules	Unauthorized Task/Operation
Inadequate Personal Protective Equipment	Unsafe Design/Construction
Incorrect/Defective/Unavailable Tool(s)	Workstation Layout is Faulty
Inexperience of Person in the Task	Other (specify in box below – be specific)

Actions and Follow Up to Prevent Recurrence (

Part F

Investigated by:

Name of Supervisor: Telephone Number:

Supervisor Signature:

Reviewed by:

Department Chair/Unit Head Signature: Date:

Employee Signature: Date:

Email completed form (within 24 hours) to uwoaiir@uwo.ca or fax to 519-661-3420 (83420)

Part G

Supervisor to distribute copies to:

- Budget Unit Head/Chair/Supervisor
- Employee/Student/Visitor
- Originator of AIIR
- Unit/Department Health