POLICY: ACCIDENT / ILLNESS / INCIDENT REPORTS			NUMBER: S-11
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PREPARED BY: Facilities Management (FM)	**AUTHORIZED BY** Andrew Konowalchuk	**CLASSIFICATION:** Safety Procedure	**EFFECTIVE:** April 24, 2023
			SUPERSEDES: July 1, 2015

An Accident/Illness/Incident Reporting Form & Investigation Report (AIIR) must be completed by supervisors whose employees were involved in an accident or incident during working hours. The report will be completed using the standard Accident/Illness/Incident Reporting Form & Investigation Report (see attached). Upon completion, copies of the report will be forwarded to the Operations Administrative Assistant as soon as possible, and must be within 24 hours of the employee accident.

It is the responsibility of the supervisor to ensure that all sections of the report are accurately completed, and all the required information is provided. For example, in the describing the accident, it is essential that the work being carried out at the time of the accident (or employee's activities) be specified on the report form.

Under the section "Actions and Follow up to prevent Recurrence", it is essential that the supervisor states any recommendations, suggestions or changes in procedure(s) which will be implemented to prevent a similar accident from occurring in the future.

Accident/Illness/Incident Investigation Reports completed by Building Services Coordinators must be submitted to the Building Manager first for review and signature, and then to the Operations Administrative Assistant, who will obtain the Director signature and distribute.

Accident/Illness/Incident Investigation Reports completed by Trades Managers will be submitted to the Operations Administrative Assistant, who will obtain the Director signature and distribute.

All AIIRs should be sent to the Operations Administrative Assistant by email through fm-aiir@uwo.ca. The Operations Administrative Assistant will route complete AIIRs to Health, Safety & Wellness, FM's Associate Vice-President, Department Director, and Department Manager.

All accidents in the workplace must be investigated immediately by the appropriate supervisors and corrective measures must be implemented to prevent re-occurrence.

REFERENCES

- **Accident/Illness/Incident Reporting Form & Investigation Report** (attached)

Accident/Illness/Incident (AII) Reporting Form & Investigation Report

Email Completed Form (*within 24 hours)* to: uwoaiir@uwo.ca
or Fax to: 519-661-3420

SECTION #1 – Accident/Illness/Incident Reporting Form

PART A

Name of Employee: _____ **Employee Number:** _____

Contact Telephone Number of Employee: (Home)_____ **(Cell)**_____

Employee Group*(if applicable)*: □ UWOSA □ PMA □ CUPE 2361 □ CUPE 2692 □ IUOE □ PSAC 610 □ SAGE □ UWOFA □ UWOPA

Status: □RF □RP/TM □CW □Undergrad Student □Grad Student □Other/Visitor

Type: □ Occ. Illness □Accident □Incident □No Injury/Hazard □ First Aid □ Lost Time □ Non-Lost Time

PART B

Date & Time of AII: _____ Day/Month/Year **Time:** _____ a.m/p.m

Date & Time AII Reported: _____ Day/Month/Year **Time:** _____ a.m/p.m.

Description of Accident/Illness/Incident:(*What happened to cause the AII? What was the person doing? Was there any equipment, people or materials involved- identify the size, weight and type)*

Part of body injured (specify left or right side):

_____

_ Location/Area of AII or Hazardous Situation (Building and Rm #):

_____

Name & Contact Information of Witness(es): _____
(If there are witnesses, please include a statement from each witness)

PART C

Treatment of Injury:

1. **Did the Employee/Student receive First Aid and by whom?** YES □ NO □
   If YES, give treatment details: _____
2. **Did the Employee/Student visit Workplace/Student Health?** YES □ NO □
3. **Did the Employee visit Hospital and/or Physician?** YES □ NO □
   If YES, what hospital/physician, date & time, address, phone number & give transportation details(e.g. ambulance) :

_____

To your knowledge, has the person had a similar disability? If YES, please explain below YES □ NO □

_____

SECTION #2 – Investigation Report

PART D

Immediately investigate if any of the following occur: Fatalities, Critical Injuries, Lost Time, Occupational Illness, Property Damage, Fire or Environmental Release

Is the employee off work due to this AII ? ☐ Yes ☐ No

Date & Hour Last Worked: _____ a.m./p.m.
Day/Month/Year/Time

Employee Return to Work Date: _____ a.m./p.m.
Day/Month/Year/Time

Normal Working Hours & Days:

	Sun	Mon	Tue	Wed	Thu	Fri	Sat
Time							
Hours							

PART E

Contributing Factors (Check √ applicable factors):

- ☐ Hazardous method/procedure used
- ☐ Improper position/posture (ergonomics)
- ☐ Inadequate personal protective equipment
- ☐ Incorrect/defective tools
- ☐ Unsafe design or construction
- ☐ Poor weather conditions
- ☐ Hazardous housekeeping or arrangement
- ☐ Inexperience of person in the task
- ☐ Training/job instruction inadequate
- ☐ Inadequate guarding of material & equipment
- ☐ Inadequate lighting/ventilation
- ☐ Other: _____

_____

Detail Factors: _____

Actions and Follow up to prevent Recurrence:

- ☐ Contact Occupational Health & Safety for assistance
- ☐ Contact Facilities Management for assistance
- ☐ Actions to improve design/procedures
- ☐ Correct congested area
- ☐ Repair or replace tool/equipment
- ☐ Improve personal protective equipment
- ☐ Install guard or safety device
- ☐ Reinstruct person involved & provide support/coaching
- ☐ Request Ergonomic Assessment
- ☐ Update training
- ☐ Refer to Employee Well-being for support

**** Supervisor to provide a detailed Action Plan below****

ACTION PLAN

Action Plan (include what, why & how recommendations are made)	Party Responsible	Completed Date	Follow Up

PART F

INVESTIGATED BY:

Name of Supervisor: _____ **(print name)** **Telephone Number:** _____

Supervisor Signature: _____ **Date:** _____

REVIEWED BY:

Management (Department Chair or Unit Head) Signature:

_____ **Date:** _____

Employee Signature: _____ **Date:** _____

JOHSC Rep Signature: _____ **Date:** _____
(if applicable)

OHS Signature: _____ **Date:** _____
(if applicable)

****FAX COMPLETED FORM TO 519-661-3420 OR EXT 83420 (ON CAMPUS)****

PART G Distribution List:

Initial - Sent Off:

Distribute copies to:
(Supervisor to do)

1) *Workplace/Student Health Services (UCC 25)* _____
2) *Budget Unit Head/Supervisor or Chair* _____
3) *Employee/Student/Visitor* _____
4) *Originator* _____
5) *Applicable Employee's Union/Staff Group – JOHSC Rep*
   - *UWOSA-UCC 255* _____
   - *PMA-UCC 351* _____
   - *CUPE 2361 FM-SSB 1320* _____
   - *CUPE 2692 HS -Perth Hall 152* _____
   - *UWOPA-LwH 1257* _____
   - *IUOE* _____
   - *PSAC 610-UCC 270* _____
   - *SAGE-STvH 3107P* _____
   - *UWOFA-ELBORN* _____
6) *Unit/Department Health & Safety Officer* _____

WITNESS STATEMENT ***(Include for each witness when submitting AIIR)***

Name of Witness: _____

Contact Information: _____

Phone/Ext: _____

Date and Time of Accident/Incident: _____

Injured Worker's Name: _____

Location of Accident/Incident: _____

Your Account of the Accident/Incident:

Name of Witness: _____ **Date:** _____

Signature of Witness: _____

ADDITIONAL INFORMATION

Name: _____ **Date:** _____

Signature: _____