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 ☐ Grad Student ☐ Other/Visitor

Type: ☐ Occ. Illness ☐ Accident ☐ Incident ☐ No Injury/Hazard ☐ First Aid ☐ Health Care ☐ Lost time ☐ No Lost Time

Part B

Date of Accident/Illness/Incident: _____ Time of Accident/Illness/Incident: _____ ☐ am ☐ pm

Date Reported: _____ Time Reported: _____ ☐ am ☐ pm

Reason for Report (**Check all that apply**):

☐ Abrasion/Contusion	☐ Cut/Laceration	☐ Heat Stress	☐ Psychological
☐ Allergic Reaction	☐ Dizziness	☐ Medical Symptoms	☐ Slip/Trip/Fall
☐ Animal/Insect Bite	☐ Fire/Explosion	☐ Loss of Consciousness	☐ Sprain/Strain
☐ Blood/Body Fluid Exposure	☐ Fracture	☐ Motor Vehicle Accident	☐ Struck by/Struck against
☐ Burn	☐ Hazardous Substance	☐ Needle Stick	☐ Violence/Harassment

☐ Other (if "other" explain – be specific)

_____

Description: In the box below, provide a description of Accident/Illness/Incident: (What happened? What was the person doing? Was there any equipment, people or materials involved (identify the size, weight, and type?).

_____

Specify Body Part (e.g., left or right side): _____

In the box below, please provide the location/area of the Accident/Illness/Incident or hazardous situation (Building, room number, floor, level, inside/outside – be specific).

Location: _____

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. To your knowledge, has the person had a similar illness/injury? ☐ Yes ☐ No
   If yes, please explain: _____

Part D

Is the Employee off work due to this Accident/Illness/Incident? ☐ Yes ☐ No

Date Last Worked: _____ Hour Last Worked: _____ ☐ am ☐ pm

Return to Work Date: _____

If the **Employee works a regular schedule**, please provide:

	Sun	Mon	Tue	Wed	Thu	Fri	Sat
Start/End Time							
Hours/Shift							

If the **Employee works a repeating rotational shift**, please provide:

Number of days on: _____ Number of days off: _____ Hours per shift: _____ Number of weeks in cycle: _____

If the **Employee works a varied or irregular work schedule, please check this box** ☐

Was modified work discussed with the employee? ☐ Yes ☐ No

Was modified work offered to the employee? ☐ Yes ☐ No

If yes, was it accepted or declined? _____

Describe the type of modified work offered (be specific):

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

Actions and Follow Up to Prevent Recurrence (**Check all that apply**):

☐ Actions to Improve Design/Procedures
☐ Contact Facilities Management for Assistance
☐ Contact Occupational Health & Safety for Assistance
☐ Correct Congested Area
☐ Improve Personal Protective Equipment
☐ Improve Preventive Maintenance Program
☐ Install Guard or Safety Device
☐ Other (specify in box below – be specific)
☐ Obtain Proper Tool/Equipment
☐ Order Job Safety Analysis to Completed
☐ Refer to Employee Well-being
☐ Reinstruct Person Involved and/or Provide Coaching
☐ Repair/Replace Tool/Equipment
☐ Request Ergonomic Assessment
☐ Update Training

Action Plan: Supervisor to provide a detailed Action Plan

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

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 & Safety Officer
☐ Applicable Employee's Union/Staff Group- JOHSC Rep

☐UWOSA (info@uwosa.ca) ☐PMA (gdhami2@uwo.ca) ☐CUPE 2361 (dstanley@uwo.ca)

☐CUPE 2692 (spaiva@uwo.ca) ☐OPSEU (jvanhaar@uwo.ca) ☐IUOE (lpellar2@uwo.ca)

☐SAGE – (amy.vandamme@uwo.ca) ☐UWOFA (peter.chidiac@schulich.uwo.ca)

☐UWOFA-LA- (peter.chidiac@schulich.uwo.ca) ☐ PSAC 610/Post Doc (johsc.psac610@gmail.com)

Witness Statement (include for each witness when submitting AIIR)

Name of Witness and **phone number**:

Date and Time of Accident/Incident:

Injured Worker's Name:

Location of Accident/Incident:

Your Account of the Accident/Incident:

Signature of Witness: Date: