Carleton University
Office of Risk Management
Environmental Health & Safety

Incident Report

- All health care and lost time incidents that are work-related are required to be reported by law.
- If this is a Critical Injury, contact EHS immediately.
- Arrange first aid treatment or health care if needed.
- Lost time begins once an employee is absent or unable to work on any day after the incident due to work-related injury.

1. Person involved

Role during Incident/Injury: ☐ Employee ☐ Student ☐ Visitor/Volunteer

First Name:	Last name:	CUID:
Department:	Union:	

2. Incident/injury details

Type of Incident:

☐ No Injury/Near Miss/Hazard ☐ Injury with No Treatment ☐ Health Care (treatment, tests by Doctor, Hospital, Health Facility) ☐ First Aid (bandage, ice pack etc.)

Date of Incident (DD/MM/YY)	Time of incident	Date reported to Supervisor:	Time reported to Supervisor:
Name of supervisor that incident/injury was reported to (Name & Position):			
Specific location of incident/illness - building, floor, room. Identify type of space: lab, office, street/ pathway /parking lot):			
Are you aware of any witnesses or persons involved in this accident/illness? ☐ Yes ☐ No If yes, provide name(s),			

- Describe what the worker was doing at the time and what occurred.
- Specify the resulting injury or type of hazardous exposure.
- Conditions that may have contributed. E.g., work area, equipment, procedure, animal, environment (noise, chemical, gas etc.).
- For a condition that occurred gradually over time, include a description of the physical activity required to do the work.

Attach additional page if necessary.

Type of Accident/Illness: Please check all that apply

☐ Struck/Caught ☐ Overexertion ☐ Repetition ☐ Slip/Trip ☐ Fall from height
☐ Harmful Substances/Environmental (chemical, etc.) ☐ Animal
☐ Needle stick - specify exposure type
☐ Motor Vehicle Incident ☐ Assault ☐ Other

Area of Injury (Body Part): Please check all that apply

☐ Head ☐ Face ☐ Teeth ☐ Neck ☐ Chest ☐ Upper Back ☐ Lower Back ☐ Abdomen ☐ Pelvis
☐ Other
Left
☐ Eye ☐ Shoulder ☐ Arm ☐ Elbow ☐ Forearm ☐ Wrist ☐ Hand ☐ Fingers
☐ Ear ☐ Hip ☐ Thigh ☐ Knee ☐ Lower leg ☐ Ankle ☐ Foot ☐ Toe(s)
Right
☐ Eye ☐ Shoulder ☐ Arm ☐ Elbow ☐ Forearm ☐ Wrist ☐ Hand ☐ Fingers
☐ Ear ☐ Hip ☐ Thigh ☐ Knee ☐ Lower leg ☐ Ankle ☐ Foot ☐ Toe(s)

3. **Health Care. Has there been or will there be health care/medical attention**? ☐ Yes ☐ No

When did/will the person receive health care for this injury (DD/MM/YY)?:

Name, address and phone number of health professional(s) or facility who treated the person:

4. Investigation / Corrective Action – * THIS SECTION TO BE COMPLETED BY SUPERVISOR

Causes contributing to incident: There may be more than one, check all that apply

☐ Unsafe equipment or tools ☐ Unsafe loading, lifting, and placing ☐ Hazardous method/procedure ☐ No identified procedure or lack of SOP ☐ Inadequate training ☐ Fire, explosion, atmospheric hazard	☐ Failure to use personal protective equipment / used incorrect PPE ☐ Unsafe posture, position, ergonomics ☐ Failure to follow established procedures ☐ Lack of experience, skill of person performing task or using equipment ☐ Hazardous housekeeping ☐ Personal medical condition	☐ Hazardous workspace/ facility ☐ Hazardous personal attire ☐Hazardous condition, weather ☐ Repetitive action ☐ Sharps-related ☐ Other – please explain:

What Corrective action or changes can be made to avoid recurrence: (Please check all that apply)

☐ Contact Facilities (PPS) ☐ Arrange an ergonomic assessment ☐ Remove hazard ☐ Clarify SOP/Procedures	☐ Repair, replace tool or equipment ☐ Provide hazard-specific training/ highlight content in training ☐ Routinely inspect areas for hazards	☐ Redesign task ☐ Other – please explain:

Supervisor / Department representative – Print Name and Signature:

Date: