THE UNIVERSITY OF WESTERN ONTARIO
ACCIDENT/INCIDENT INVESTIGATION REPORT
FAX COMPLETED FORM TO: 661-2079 (82079)
MAIL TO: Room 294, Stevenson-Lawson Building, Rehabilitation Services
(To be completed, signed and submitted by the Supervisor within 24 hours of the accident/incident)

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

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: □Accident □Incident □No Injury/Hazardous Situation

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

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

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

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If there are witnesses, please include a statement from each witness:

Name & Contact Information of Witness: _____

Name & Contact Information of Witness: _____

Location/Area of Accident/Incident (Building and Rm #): _____

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

Treatment of Injury:
1. **Did the Employee/Student receive First Aid?** **Yes □ No □**
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 and time, address, phone number :

_____

To your knowledge, has the person had a similar disability? If Yes, please explain below. □ Yes □ No

COMPLETE THIS SECTION IF THE EMPLOYEE HAS LOST TIME MORE THAN THE DAY OF ACCIDENT

Is the employee off work due to this accident/incident □ **Yes** □ **No**

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

Normal Working Hours & Days:

Sun	Mon	Tues	Wed	Thurs	Fri	Sat

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

Complete the following Sections and include additional pages if necessary:

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:	**Completed:**	**Date Completed/To be Completed:**
□ **To contact Occupational Health & Safety for assistance**	□ **Yes** □ **No**	_____
□ **To contact Physical Plant Department for assistance**	□ **Yes** □ **No**	_____
□ **Actions to improve design/procedures**	□ **Yes** □ **No**	_____
□ **To correct congested area**	□ **Yes** □ **No**	_____
□ **To repair or replace tool/equipment**	□ **Yes** □ **No**	_____
□ **To improve personal protective equipment**	□ **Yes** □ **No**	_____
□ **To install guard or safety device**	□ **Yes** □ **No**	_____
□ **To reinstruct person involved & provide support/coaching**	□ **Yes** □ **No**	_____
□ **To request Ergonomic Assessment**	□ **Yes** □ **No**	_____
□ **To update training**	□ **Yes** □ **No**	_____
□ **To refer to Rehabilitation Services**	□ **Yes** □ **No**	_____

Detail Actions Taken to prevent Recurrence:

_____

_____

_____

Name of Budget Unit Head/Supervisor: _____(print name) Telephone Number: _____

Signature: _____ **Date: _____**

Distribute copies to:

	Distributed:
1) Workplace/Student Health Services(UCC 25)	□ **Yes** □ **No**
2) Budget Unit Head/Supervisor or Chair	□ **Yes** □ **No**
3) Employee/Student/Visitor	□ **Yes** □ **No**
4) Originator	□ **Yes** □ **No**
5)Employee's Union/Staff Group – JOHSC Rep	
UWOSA-UCC 255	□ **Yes** □ **No**
PMA-UCC 351	□ **Yes** □ **No**
CUPE 2361 PPD-SB	□ **Yes** □ **No**
CUPE 2692 Food Services-Perth Hall 152	□ **Yes** □ **No**
UWOPA-SLB 57G	□ **Yes** □ **No**
IUOE-SB	□ **Yes** □ **No**
PSAC 610-UCC 270	□ **Yes** □ **No**
SAGE-SLB 212G	□ **Yes** □ **No**
UWOFA-WR93 202	□ **Yes** □ **No**

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:

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

Signature of Witness: _____

.ADDITIONAL INFORMATION (To be included with AIIR)

Name: _____ **Date:** _____

Signature: _____