



Injury / Incident Report

NO INJURY

INJURY

INSTRUCTIONS ON PAGE 3

Hazardous Situation

First Aid Healthcare Blood/Body Fluid Exposure
 Lost Time Critical Injury No First Aid

IMPORTANT – IF PERSONAL INJURY IS INVOLVED, FORM MUST BE FAXED WITHIN 24 HRS. OF THE INCIDENT TO EITHER ENVIRONMENTAL & OCCUPATIONAL HEALTH SUPPORT SERVICES (FAX# 905.540.9085, GH 304) OR FACULTY OF HEALTH SCIENCES SAFETY OFFICE (FAX# 905.528.8539, HSC 1J11)

SECTION 1: TO BE COMPLETED BY INDIVIDUAL REPORTING INCIDENT

LAST NAME	FIRST NAME	EMPLOYEE ID/STUDENT ID (if applicable)
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DEPARTMENT/UNIT	EXTENSION	Occupation at the time of injury: _____ Years of service to McMaster in occupation: _____
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AFFILIATION EMPLOYEE STUDENT OTHER (Please specify): _____

UNION/EMPLOYEE GROUP CUPE CAW IUOE MUFA TMG SEIU CASUALS MUALA OTHER

DD/MM/YY OF INCIDENT	TIME OF DAY <input type="checkbox"/> AM <input type="checkbox"/> PM	DD/MM/YY REPORTED	TIME OF DAY <input type="checkbox"/> AM <input type="checkbox"/> PM
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DESCRIPTION OF INCIDENT **INCIDENT LOCATION:** BLDG. NAME _____ ROOM # _____

STATE EXACTLY THE SEQUENCE OF EVENTS LEADING UP TO THE INCIDENT:

- (1) WHAT WERE YOU DOING AND DESCRIBE THE EFFORT INVOLVED?
- (2) SIZE, WEIGHT AND TYPE OF EQUIPMENT OR MATERIALS INVOLVED (IF APPLICABLE)
- (3) WHAT HAPPENED TO CAUSE THE INJURY?
- (4) WHAT CONDITIONS ATTRIBUTED TO THE INCIDENT/ACCIDENT?
- (5) HOW COULD THE EVENT HAVE BEEN AVOIDED?

ADDITIONAL INFORMATION ATTACHED

NAME AND ADDRESSES OF WITNESSES

AREA OF INJURY

(Check all that apply)

- EYES HEAD ARMS CHEST INTERNAL DOMINANT HAND
 BACK HANDS LEGS FEET NECK LEFT RIGHT

TYPE OF INJURY

(Check all that apply)

- ABRASION/CONTUSION BURN LOSS OF CONSCIOUSNESS SPRAIN/STRAIN
 ALLERGIC REACTION CUT/LACERATION MEDICAL SYMPTOMS OTHER _____
 ANIMAL/INSECT BITE GRADUAL ONSET PUNCTURE/NEEDLESTICK

NAME OF ATTENDING PHYSICIAN (To be completed only if healthcare obtained)

 TEL: _____ DATE OF HEALTHCARE: _____

TREATMENT OF INJURY

- EMPLOYER PHYSICIAN EMERGENCY NONE
 FAMILY PHYSICIAN WALK-IN CLINIC
 OTHER (Please specify) _____

SIGNATURES

I certify that the above information is true and complete to the best of my knowledge.

PERSON REPORTING INCIDENT (PRINT NAME)	DATED	SIGNATURE
_____	_____	_____

To be completed by Individual Reporting Incident

SECTION 2: TO BE COMPLETED BY SUPERVISOR

CONTRIBUTING FACTORS

WHAT CONDITIONS CONTRIBUTED TO THE INCIDENT (✓) (Check all that apply).

- | | |
|--|---|
| 1 OPERATING WITHOUT AUTHORITY | 10 POOR HOUSKEEPING |
| 2 FAILURE TO LOCK OUT | 11 UNSAFE PRACTICE |
| 3 INSUFFICIENT TRAINING | 12 HAZARDOUS ENVIRONMENTAL CONDITION |
| 4 UNSAFE EQUIPMENT/POOR DESIGN | 13 DISTRACTING, TEASING, WILLFUL MISCONDUCT |
| 5 IMPROPER POSITION OR POSTURE | 14 INCLEMENT WEATHER |
| 6 FAILURE TO USE PERSONAL PROTECTIVE DEVICES | 15 OTHER (EXPLAIN) |
| 7 NOT GUARDED OR IMPROPERLY GUARDED | |
| 8 INADEQUATE ILLUMINATION | |
| 9 FIRE, EXPLOSION HAZARD | |

TO YOUR KNOWLEDGE HAS THE EMPLOYEE HAD A PREVIOUS SIMILAR INJURY?

YES NO

IN ADDITION TO THE CHECKLIST, PLEASE DESCRIBE IN DETAIL THE CAUSE(S) OF EVENT – ROOT CAUSES WHICH COULD INCLUDE ANY OR ALL OF THE FOLLOWING: PHYSICAL CAUSES, HUMAN CAUSES, AND ORGANIZATIONAL CAUSES.

DETAILS OF PROPERTY DAMAGE (IF APPLICABLE)

CORRECTIVE MEASURES

ACTIONS TO PREVENT RECURRENCE (✓) (Check all that apply).

- | | |
|--|---|
| 1 REINSTRUCTION OF PERSON INVOLVED | 8 ACTIONS TO IMPROVE WORK PROCEDURE |
| 2 REASSIGNMENT OF PERSON | 9 CHECK WITH MANUFACTURER |
| 3 ERGONOMIC ASSESSMENT | 10 DISCIPLINE OF PERSONS INVOLVED |
| 4 IMPROVED PERSONAL PROTECTIVE EQUIPMENT | 11 COMMUNICATION TO THE RESPONSIBLE PERSON/DEPARTMENT |
| 5 EQUIPMENT REPAIR OR REPLACEMENT | 12 OTHER (EXPLAIN) |
| 6 CORRECTION OF CONGESTED AREA | |
| 7 INSTALLATION OF GUARD OR SAFETY DEVICE | |

IN ADDITION TO THE CHECKLIST, PLEASE DESCRIBE IN DETAIL CORRECTIVE MEASURES TO PREVENT RECURRENCE

PERSON RESPONSIBLE FOR ACTION:

COMPLETION DATE:

LOST TIME INCIDENT ONLY

Scheduled Shift on Day of Injury

Date/Time Last Worked

Date/Time Returned to Work

Regular Days & Hours of Work:

S M T W Th F Sa

SIGNATURES

I certify that the above information is true and complete to the best of my knowledge.

SUPERVISOR / EXTENSION # (PRINT NAME)

DATED

SIGNATURE

DEPARTMENT HEAD (PRINT NAME)

DATED

SIGNATURE

To be completed by Supervisor

Instruction for Completing Form

The employee has the responsibility of reporting incidents promptly. The employee and the supervisor must fill out the designated portions of this form and the employee, supervisor and department head (chair, director, etc.) must sign it. The supervisor is responsible for investigating the accident and for ensuring corrective action to prevent a recurrence of the incident for due diligence purposes. If personal injury is involved, all appropriate procedures must be followed (please refer to RMM 1000 and 1002). The report must be forwarded immediately to Environmental and Occupational Health Support Services at 905.540.9085, or for areas in the Faculty of Health Sciences, forward to the Safety Office at 905.528.8539. If you require additional assistance, please contact Environmental & Occupational Health Support Services at ext. 24352 or the Health Sciences Safety Office at ext. 24956.

TYPES OF INCIDENTS TO REPORT

HAZARDOUS SITUATION – Refers to an incident caused by an unsafe act, an unsafe condition or a combination of both in the work environment which could have resulted in property loss and/or physical harm.

FIRST AID INJURY – An injury of such minor nature that treatment can be carried out by application of a band aid, cold compress or any other content of a first aid kit.

HEALTHCARE INJURY – An incident which requires treatment or service rendered by a health care professional but does not result in time lost from work other than the day of injury.

LOST TIME INJURY – Refers to an injury which results in time lost from work beyond the day of the injury.

BLOOD / BODY FLUID EXPOSURE – Refers to exposure to body fluids with the capability of transmitting disease organisms, i.e. blood, seminal fluid, vaginal secretions, cerebral spinal fluid, synovial fluid, pleural fluid, peritoneal fluid, pericardial fluid, amniotic fluid and tissues.

Critical Injury is defined as an injury of a serious nature that:

- places life in jeopardy;
- produces unconsciousness;
- results in substantial loss of blood;
- involves the fracture of a leg or arm, but not a finger or toe;
- involves the amputation of a leg, arm, hand or foot, but not finger or toe;
- consists of burns to a major portion of the body; or
- causes the loss of sight in an eye.

In the case of a critical injury, supervisors are responsible for:

1. Securing the accident site and ensure that further injury is prevented.
2. Immediately arranging for medical and emergency assistance by call Security at “88” or “5555” at host hospitals and “911” at any other off-campus locations.
3. Immediately notifying Environmental and Occupational Health Support Services at ext. 24352 and communicate details of the incident.
4. Ensure that the site remains undisturbed until Environmental and Occupational Health Support Services provide clearance.
5. Cooperating with directives from Environmental and Occupational Health Support Services and the Ministry of Labour.

RESPONSIBILITIES

Employee Responsibilities

1. Promptly receive appropriate medical treatment.
2. Notify supervisor as soon as possible of injury and any related healthcare.
3. Assist with the completion of Injury/Incident form and sign it.
4. Assist in the incident investigation and implementation of any corrective action.
5. Adhere to the legal requirements of WSIB and participate in McMaster University’s Return to Work Program if modified work and/or lost time results from a work related injury.

Supervisor Responsibilities

1. Ensure that the injured employee receives appropriate medical treatment in the case of personal injury.
2. Provide transportation for the injured employee to a healthcare practitioner or Emergency and provide a Functional Abilities Form.
3. Report the injury/incident to Environmental and Occupational Health Support Services or the Faculty of Health Sciences Safety Office using the Injury/Incident Form.
4. Investigate the incident as soon as possible and take corrective actions when appropriate to prevent reoccurrence.
5. Inform Environmental and Occupational Health Support Services and Employee Health Services promptly if an employee has been diagnosed with an occupational disease.
6. Inform Employee Health Services at ext. 23564 / 23454 if healthcare was sought and/or employee lost time from work, of any return to work or any change in the employee’s status.
7. If person responsible for corrective measures/completion date is unknown, the Incident/Injury report is to be submitted with this information to follow when available.
8. If the Supervisor or Department Head is unavailable to sign the injury/incident report, the report should be submitted with all available signatures and resubmitted with remaining signatures when possible.

The information gathered on this form is collected under the authority of the *McMaster University Act, 1976*. The information is used for the academic, administrative, employment-related, financial and/or statistical purposes of the University including, but not limited to, admissions; registration and maintaining records; awards and scholarships; convocation; provision of student services, including access to information systems; alumni relations; and disclosure to or on the behalf of the applicable McMaster student government. This information is protected and is being collected pursuant to section 39(2) and section 42 of the *Freedom of Information and Protection of Privacy Act* of Ontario (RSO 1990).

Questions regarding the collection or use of this personal information should be directed to the University Secretary, Gilmour Hall, Room 210, McMaster University.

In addition to collecting personal information for its own purposes, McMaster University collects specific and limited personal information on behalf of the McMaster Student Union, the McMaster Association of Part-time Students and/or the McMaster Graduate Students Association. The groups use the information for the purpose of membership, administration, elections, annual general meetings, health plans and other related matters only. Please contact the relevant Student Union/Association office if you have questions about this collection, use and disclosure of your personal information.

ABOVE INFORMATION TO BE USED FOR COMPLETION OF WSIB CLAIM FORM #7

PLEASE PROVIDE A COPY TO:
HR/Rev Dec 2011

Department Chair, Manager or Director

Environmental & Occupational Health Support Services

Employee/Other

RETURN TO: EOHSS, GH 304 (Fax# 905.540.9085) OR HEALTH SCIENCES SAFETY, HSC 1J11 (Fax# 905.528.8539)