HEALTH & SAFETY INCIDENT REPORT

(including workplace accidents, injuries, illness and near misses/property damage)

PART 1: to be completed with patient information OR the person reporting the near miss/property damage

Last Name:	First Name:	Date of Report:
Street Address:	City/Prov:	Postal Code:
Home Telephone:	Work Telephone:	Date of Birth (YYYY/MM/DD):
Employee/Student Okanagan College ID #:	Location where injury/incident took place (Campus/Building/Room No):	
Job Title (or student/visitor):	If incident is off campus, please indicate purpose and address: ◯ Apprenticeship ◯ Student Practicum ◯ Other: _____	
Date & Time of Injury/Incident:	First reported to (check one and include name): ◯ Supervisor	
Date & Time Reported:	◯ Instructor	
	◯ First Aid Attendant	

PART 2: To be completed as soon as possible. If uncertain or information is missing, additions can be submitted later

Names and address of witnesses:

Accident/Incident category:	☐ No injury	☐ Medical Treatment	☐ Property Damage	☐ Fire
	☐ Other (please specify)			
Severity of injury or illness:	☐ First Aid Only	☐ Medical Treatment	☐ Disabling	☐ Fatal

Nature of injury or illness (describe location of injury and if it seems to be a bruise, cut, twist or the onset of symptoms):

Description of how the incident/accident took place (or employee's account of illness):

Describe the results of incident or illness (property damage, type of injury such as a sprain, concussion, nature of illness), first aid required and disposition (return to work, to clinic for stitches, need x-rays, etc):

Any time loss on day of injury?	◯ Yes	◯ No	Any time loss beyond the day of injury?	◯ Yes # of days ____	◯ No

Note: If there is any time loss or if you see a doctor at a later date, you must **notify your supervisor/instructor and the Health & Safety Department (*250-862-5405*) immediately** to ensure that the appropriate forms are submitted to WorkSafeBC within the legislated timeframe of three calendar days (employees, apprenticeship students, or students on practicum).

See next page...

PART 3: To be completed by Supervisor/Instructor	**Name:**	
Were person's actions at time of injury/incident for the purpose of OC business?	◯ Yes	◯ No
If NO, explain:		
Were person's actions at time of injury/incident part of his/her regular work?	◯ Yes	◯ No
If NO, explain:		
Was any person not employed by OC responsible for this injury/incident?	◯ Yes	◯ No
If YES, provide name and address of such person:		
Are you aware of any previous pain or disability in the area of the present injury?	◯ Yes	◯ No
If YES, explain:		
Are you aware of any disability of the worker prior to injury?	◯ Yes	◯ No
If YES, explain:		

What are the basic causes and contributing factors to the injury/illness? Explain in full any unsafe acts, conditions or personal factors that need to be corrected or clarification of occupational health and safety requirements:

Supervisor/Instructor Signature:	**Date:**

PART 4: To be completed by Occupational Health & Safety	**Name:**

Corrective Actions:

1) Action required:

2) By whom:

3) By when:

Name(s) and role(s) of person(s) who investigated accident (usually Joint Occupational Health and Safety Committee members):

Completed form to be forwarded IMMEDIATELY to the Occupational Health&Safety Coordinator. ***In the event of a serious incident, phone the Coordinator immediately (250-862-5405)*** **so that a full investigation may commence to avoid further injuries/damage.**