HEALTH AND SAFETY INCIDENT REPORT FORM

INSTRUCTIONS Fill out this form immediately after a work-related incident and submit it to:

REPORTED BY	DEPARTMENT

PHONE	EMAIL

INCIDENT DETAILS

LOCATION	DATE OF INCIDENT	TIME

INCIDENT TYPE *select one*

	ACCIDENT		INCIDENT		NEAR MISS
	VIOLENCE		ILL HEALTH		SAFETY

INCIDENT DESCRIPTION
Report any details that may have contributed to the incident. Attach additional information as necessary.

OUTCOME DESCRIPTION
Detail all harm / health effects / damage.

CORRECTIVE MEASURES
Describe corrective measures taken to address immediate hazards related to the incident.

INDIVIDUAL AFFECTED

NAME	EMPLOYEE ID	DATE OF BIRTH

POSITION job title or designation, i.e. visitor, contractor, etc.

WORK PHONE	WORK EMAIL

PERSONAL PHONE	PERSONAL EMAIL

HOME ADDRESS

EMPLOYER NAME if individual affected is not an employee	EMPLOYER PHONE

EMPLOYER ADDRESS

WITNESS DETAILS

NAME	CONTACT INFORMATION

FIRST AID

FIRST AID ADMINISTERED?

	YES	ADMINISTERED BY	
	NO	CONTACT INFORMATION	
	N/A	TIME OF ADMINSTRATION	

DETAILS OF FIRST AID ADMINISTERED

POST INCIDENT

WHERE DID THE INDIVIDUAL AFFECTED GO NEXT? *select one*

	TO THE HOSPITAL		HOME		RETURNED TO WORK		OTHER

EXPLANATION / FURTHER DETAILS IF OTHER

Was a member of the joint health and safety committee notified of the incident?

	YES	INDIVIDUAL CONTACTED	
	NO	CONTACT INFORMATION	

ADDITIONAL NOTES

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