DURHAM CATHOLIC DISTRICT SCHOOL BOARD

Work Related Incident Investigation Report

(to be completed by Principal/Supervisor)

IF THIS IS A CRITICAL INJURY AS DEFINED BY THE OCCUPATIONAL HEALTH AND SAFETY ACT, PLEASE CONTACT THE HEALTH AND SAFETY OFFICER AND FAX IMMEDIATELY TO 905.576.1981 A DELAY COULD RESULT IN A MINIMUM FINE OF $250.00

A. Employee Information

Name: ______________________________ (Surname - First Name)		School/Department:
Address: (including Postal Code)		Telephone: Home:
Date of Employment:		Work:
Occupation: ______________________________ (At time of work related incident)		Family Doctor:
Number of years in occupation:	Social Insurance Number	Language (Other than English)

B. Details of Incident

Type of Incident (check one): ☐ Struck or contact by ______________ ☐ Struck against or contact with ☐ Caught in, on or between ☐ Fall (specify)_______________ ☐ Over exertion/strain ☐ Exposure to:________________ ☐ Other (specify) _____________________ ____________________________	Date & Time of Incident: __________ (d/m/y) @ _____ ☐a.m. ☐p.m. Date & Time Reported: __________ (d/m/y) @ _____ ☐a.m. ☐p.m.

Describe in detail the following:

(a) sequence of events leading up to the incident,

(b) where the incident occurred,

(c) what the employee was doing at the time,

(d) the size, type & weight of equipment or materials involved:

(e) type of injury (ie: scrape, bruise, strain, fracture, cut, etc.), part(s) of body involved and specify left or right side

Please fax to: 905.576.1981

Distribution: Forward to Health & Safety Officer, Catholic Education Centre

Names, addresses & telephone numbers of witnesses or persons having knowledge of incident:

To your knowledge, has the employee had a previous similar disability/incident? ☐ Yes ☐ No
If yes, please provide details.

Which of the following conditions contributed to the incident (please number in order of importance - 1, 2, 3)

___ Operating without authority
___ Working at unsafe speed
___ Unsafe loading, placing, mixing, combining, etc.
___ Working on moving or dangerous equipment
___ Failure to use personal safety devices
___ Not guarded or improperly guarded
___ Fire, explosion, atmospheric hazard
___ Unsafe design or arrangement
___ Outside hazardous condition
___ Failure to secure or warn
___ Unsafe equipment
___ Unsafe position or posture
___ Distracting, teasing, wilful misconduct
___ Wheeled equipment operation
___ Inadequate illumination
___ Hazardous personal attire
___ Hazardous method or procedure
___ Other (specify):

Details of property damage:(if any)

C. Result

☐ NO INJURY Hazardous Situation	☐ INJURY No W.S.I.B. Claim - first aid only	☐ INJURY W.S.I.B. Claim Medical Attention	☐ INJURY W.S.I.B. Claim Lost Time
Employee's Signature:	Supervisor's Signature:	Date:	

D. Prevention of Recurrence

Check off action(s) that you have taken and indicate date action(s) taken to prevent recurrence; mark other corrective actions intended but not yet taken with a 'P'.

___ Reinstruction of person involved
___ Actions to improve design/procedure
___ Equipment repair or replacement
___ Order job safety analysis done
___ Improved personal protective equipment
___ Inform all department staff
___ Action to improve inspection
___ Reassignment of person involved
___ Check with manufacturer
___ Correction of congested area
___ Installation of guard or safety devices
___ Other (specify)_________________________________
____

Describe how you have or will implement the above action(s) to prevent recurrence and include timelines:

E. Additional Comment

Please fax to: 905.576.1981