MEMORIAL UNIVERSITY

Department of Health and Safety

Accident/Incident Report Form

To be completed by the immediate supervisor and forwarded to the Department of Health & Safety - health.safety@mun.ca, immediately following notification of the accident/incident. Answer all questions, or signify if not applicable with N/A. Please complete both sides.

PART 1 – To be completed in ALL cases							
Employee - Surname	Given Names		1. Time of Injury:	hour | min	am / pm	yy|mm|dd	
			2. Time Reported to Employer:	hour | min	am / pm	yy|mm|dd	
Position	Employee Number		3. If not reported promptly, explain why:				
Department	Work Phone		4. To Whom was Report Made?	Name			
				Position			
Supervisors Name & Position			5. Exact Location of the Incident:				
6. What specific act was worker performing when incident occurred?							
7. What specific equipment and/or materials was being used at the time of the incident?							
8. What unexpected event occurred to cause the incident?							
9. Part of Body Injured (Indicate Whether Left or Right Side):							

10. Estimation of Nature of Injury (Check one or more):							
Amputation	☐	Bruise or Contusion	☐	Cut	☐	Hernia	☐
Burn or Scald (thermal)	☐	Concussion	☐	Laceration or Abrasion	☐	Illness	☐
Burn (chemical)	☐	Crushing Injury	☐	Bone Fracture	☐	Sprain or Strain	☐
Other (specify)							

11. Was first aid administered?		By whom?	
12. Was medical treatment administered?		If yes, indicate hospital and doctor:	
13. List any witnesses to the incident:			
14. Was there any other person, directly or indirectly, responsible or involved?		Explain:	
15. Was this injury related to a previous on-the-job injury?		Approximate date of previous injury:	

PART 2–Please complete this section ONLY if worker has been absent from work as a result of this incident for longer than the day of injury.									
16. Time employee was first disabled from work:	hour | min	am / pm	yy|mm|dd	If employee has returned to work, give time he/she did so:	hour | min	am / pm	yy|mm|dd		
17. If not returned to work, how long should injury disable employee?		18. Where is employee now? (Home, Hospital, etc)							
19. Did worker work at all after being first disabled?		20. Period Worked	From	yy | mm | dd	To	yy | mm | dd			
21. Was it the worker's normal work?		If no, describe:							

PART 3 – SIGNED – To be completed in ALL cases			
IMMEDIATE SUPERVISOR:		DATE:	
INJURED PARTY:		DATE:	

PART 4 – Supervisor's Investigation Report –To be completed in ALL cases			
22. Explain how any of the following may have contributed to this accident/incident:			
A. Worker (attitude, physical condition, mental alertness, etc.)			
B. Method of Procedure (training, familiarity, planning, etc.)			
C. Conduct (wilful misconduct by worker or other)			
D. Equipment and Material (condition, proper application, etc.)			
E. Surroundings (confinement, housekeeping, environmental)			
23 A. What applicable protective equipment was being used?			
23 B. What should or could be used? Please specify.			
24 A. Did you personally visit the scene of this accident/incident?		If yes, indicate date and time:	
24 B. Was affected worker present?		25. Any comments or concerns on accident site:	
26 A. Corrective action taken or planned to prevent a recurrence of this type of accident/incident:			
26 B. Do you feel that anything should be done in addition?		If yes, please explain:	
27. In your opinion is there any misrepresentation or concealment in this case?			
28. Have you reviewed this accident/incident with other workers engaged in similar work?			

PART 5 – Signatures and Comments – To be completed in ALL cases			
Immediate Supervisor:		Date:	
Comments:			
Department Head or Representative:		Date:	
Comments:			

PART 6 – Department of Health & Safety			
Reviewed By:		Date:	
Entered on Database:		Follow-up investigation required:	
Recommendation:			

PART 7 – Safety Committee Review and Comments

Detailed Incident Description

In the space provided, please describe in detail the incident.

Please answer (Who? What? Where? When? Why? How?) Be specific.

(PLEASE TYPE HERE OR ENSURE TO PRINT CLEARLY)

Injured Party's Signature: _____ Supervisor's Signature: _____

(Please Print)
Injured Party: _____

(Please Print)
Supervisor's Name _____

Send completed form, with signatures to health.safety@mun.ca