TO BE COMPLETED BY THE IMMEDIATE SUPERVISOR AND FORWARDED TO JOINT HEALTH AND SAFETY COMMITTEE, IMMEDIATELY FOLLOWING NOTIFICATION OF THE ACCIDENT / INCIDENT. ANSWER ALL QUESTIONS, OR SIGN IT NOT APPLICABLE WITH N/A. PLEASE COMPLETE BOTH SIDES.

Type of Incident:	Accident		Incident		Near Miss		Other:	
PART 1 - To be completed in ALL cases				1. Time of Injury		Hour	am/pm	date
Employee - Surname		Given Name		2. Time reported to employer		Hour	am/pm	date
Position		Employee #		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 inicdent				
6. What specific act was worker performing when incident occurred?								
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. What first aid administered			By Whom?					
12. Was medical Treatment administered			If Yes, indicate hospital and doctor			FAF provided	yes	no
Form 7 Required:	Circle:	Yes	No	Filed By Whom:				

13. Witness Names:							
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 day of injury.							
16. Time employee was first disabled from work:	HOUR	AM / PM	DATE	IF EMPLOYEE HAS RETURNED TO WORK, GIVE TIME RETURNED	HOUR	AM / PM	DATE
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		TO		
21. Was it his / her normal work?		If not, describe:					
PART 3- SIGNED - To be completed in all cases							
IMMEDIATE SUPERVISOR		DATE					
EMPLOYEE:		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 equipmen was being used?			
23. B. What should or courl 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 esle should be done in addition?		If yes, please explain.	
27. In your opinion is there any misrepresentation or concealment in this case?			
28. Have your reviewed this accident / incident with other workers engaged in similar work?			

PART 5 - SIGNATURES AND COMMENTS - To be completed in ALL cases			
Immidiate Supervisor		Date:	
Comments:			
Department Head or Representative		Date	

Comments:				
PART 6 - HEALTH AND SAFETY COMMITTEE				
Reviewed By:		Date		
Reviewed at next safety meeting?		Follow-up investigation required		
Reccommendations:				
PART 7 - Safety Committee Review and Comments:				