



Injury / Incident Report

 NO INJURY INJURY**INSTRUCTIONS ON PAGE 3** Hazardous Situation First Aid Healthcare Lost Time No First Aid**IMPORTANT – IF PERSONAL INJURY IS INVOLVED, FORM MUST BE SUBMITTED WITHIN 24 HOURS OF THE INCIDENT TO EITHER ENVIRONMENTAL & OCCUPATIONAL HEALTH SUPPORT SERVICES (EMAIL: EOHSS@MCMASTER.CA | GILMOUR HALL ROOM 304) OR FACULTY OF HEALTH SCIENCES SAFETY OFFICE (EMAIL: FHSSO@MCMASTER.CA | HEALTH SCIENCES CENTRE ROOM 1J11A)****SECTION 1: INFORMATION OF PERSON WHO WAS INJURED/ INVOLVED IN INCIDENT/REPORTING HAZARDOUS SITUATION**

LAST NAME	FIRST NAME	EMPLOYEE / STUDENT ID # (if applicable)
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DEPARTMENT/FACULTY/UNIT	CONTACT #	Occupation at the time of injury/incident/hazardous situation: _____
		Years of service to McMaster in occupation: _____

AFFILIATION EMPLOYEE STUDENT OTHER (Please specify): _____

UNION/EMPLOYEE GROUP THE BUC CUPE IUOE MUALA MUFA SEIU TMG UNIFOR OTHER: _____

DD/MM/YY OF INCIDENT	TIME OF DAY <input type="checkbox"/> AM <input type="checkbox"/> PM	DD/MM/YY REPORTED	TIME OF DAY <input type="checkbox"/> AM <input type="checkbox"/> PM
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DESCRIPTION OF INCIDENT/INJURY/HAZARD **INCIDENT LOCATION (I.E BLDG NAME):** _____ **ROOM #:** _____

(1) Describe what happened to cause the accident/illness/hazardous situation and what the individual was doing at the time (lifting a 50lb. object, slipped on wet floor, repetitive movements, etc.). Include what the injury/hazardous situation is and any details of equipment, materials, environmental conditions (work area, temperature, noise, chemical, gas, fumes, other person) that may have contributed.

(2) How could the event have been avoided?

SUDDEN SPECIFIC EVENT/OCCURANCE GRADUALLY OCCURRING OVER TIME ADDITIONAL INFORMATION ATTACHED

NAME AND CONTACT INFORMATION OF WITNESSES

AREA OF INJURY (Check all that apply)

<input type="checkbox"/> Head <input type="checkbox"/> Teeth <input type="checkbox"/> Upper Back <input type="checkbox"/> Face <input type="checkbox"/> Neck <input type="checkbox"/> Lower Back <input type="checkbox"/> Eye(s) <input type="checkbox"/> Chest <input type="checkbox"/> Abdomen <input type="checkbox"/> Ear(s) <input type="checkbox"/> Pelvis <input type="checkbox"/> Other _____	Left <input type="checkbox"/> Shoulder <input type="checkbox"/> Arm <input type="checkbox"/> Elbow <input type="checkbox"/> Forearm	Right <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Left <input type="checkbox"/> Wrist <input type="checkbox"/> Hand <input type="checkbox"/> Finger(s)	Right <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Left <input type="checkbox"/> Hip <input type="checkbox"/> Thigh <input type="checkbox"/> Knee <input type="checkbox"/> Lower Leg	Right <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Left <input type="checkbox"/> Ankle <input type="checkbox"/> Foot <input type="checkbox"/> Toes(s)	Right <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	DOMINANT HAND <input type="checkbox"/> Left <input type="checkbox"/> Right
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HAVE YOU HAD A PREVIOUS OR SIMILAR INJURY? YES NO

REASON FOR REPORT (Check all that apply)

<input type="checkbox"/> Abrasion/Contusion <input type="checkbox"/> Allergic Reaction <input type="checkbox"/> Animal/Insect Bite <input type="checkbox"/> Blood/Body Fluid Exposure <input type="checkbox"/> Burn <input type="checkbox"/> Cut/Laceration	<input type="checkbox"/> Fire/ Explosion <input type="checkbox"/> Fracture <input type="checkbox"/> Hazardous Substance <input type="checkbox"/> Heat Stress <input type="checkbox"/> Loss of Consciousness <input type="checkbox"/> Medical Symptoms	<input type="checkbox"/> Motor Vehicle Accident <input type="checkbox"/> Needle stick <input type="checkbox"/> Overexertion <input type="checkbox"/> Psychological <input type="checkbox"/> Slip/Trip /Fall <input type="checkbox"/> Sprain/Strain	<input type="checkbox"/> Struck/Caught <input type="checkbox"/> Violence/Harassment <input type="checkbox"/> Other: _____
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NAME OF ATTENDING PHYSICIAN (To be completed only if healthcare obtained) _____	TREATMENT OF INJURY <input type="checkbox"/> Emergency <input type="checkbox"/> None <input type="checkbox"/> Family Physician <input type="checkbox"/> Walk-In Clinic <input type="checkbox"/> Other (Please specify) _____
TEL: _____ DATE OF HEALTHCARE: _____	

SECTION 2: TO BE COMPLETED BY SUPERVISOR

LOST TIME INCIDENT ONLY

Scheduled Shift on Day of Injury	Date/Time Last Worked	Date/Time Returned to Work <input type="checkbox"/> regular work <input type="checkbox"/> modified work	Regular Days & Hours of Work: S M T W TH F SA _____
		Has the employee been offered modified work <input type="checkbox"/> YES <input type="checkbox"/> NO	

After the day of accident/incident this worker

Returned to his/her **regular job** and **has not** lost any time and/or earnings

Returned to **modified work** and **has not** lost any time and/or earnings.

Has lost time and/or earnings.

CONTRIBUTING FACTORS WHAT CONDITIONS CONTRIBUTED TO THE INCIDENT/INJURY/HAZARDOUS SITUATION (✓) (Check all that apply).

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|---|--|
| 1 <input type="checkbox"/> OPERATING WITHOUT AUTHORITY | 9 <input type="checkbox"/> UNSAFE PRACTICE |
| 2 <input type="checkbox"/> INSUFFICIENT TRAINING | 10 <input type="checkbox"/> HAZARDOUS ENVIRONMENTAL CONDITION |
| 3 <input type="checkbox"/> UNSAFE EQUIPMENT/POOR DESIGN | 11 <input type="checkbox"/> DISTRACTING, TEASING, WILLFUL MISCONDUCT |
| 4 <input type="checkbox"/> IMPROPER POSITION OR POSTURE | 12 <input type="checkbox"/> OTHER (EXPLAIN): _____ |
| 5 <input type="checkbox"/> FAILURE TO USE PERSONAL PROTECTIVE DEVICES | |
| 6 <input type="checkbox"/> NOT GUARDED OR IMPROPERLY GUARDED | |
| 7 <input type="checkbox"/> FIRE, EXPLOSION HAZARD | |
| 8 <input type="checkbox"/> POOR HOUSKEEPING | |

To your knowledge has the employee had a previous similar injury? YES NO

IN ADDITION TO THE CHECKLIST, PLEASE DESCRIBE IN DETAIL THE CAUSE(S) OF EVENT – ROOT CAUSES WHICH COULD INCLUDE ANY OR ALL OF THE FOLLOWING: PHYSICAL CAUSES, HUMAN CAUSES, AND ORGANIZATIONAL CAUSES.

DETAILS OF PROPERTY DAMAGE (IF APPLICABLE):

CORRECTIVE MEASURES ACTIONS TO PREVENT RECURRENCE (✓) (Check all that apply).

- | | |
|--|---|
| 1. <input type="checkbox"/> REINSTRUCTION OF PERSON INVOLVED | 8. <input type="checkbox"/> ACTIONS TO IMPROVE WORK PROCEDURE |
| 2. <input type="checkbox"/> REASSIGNMENT OF PERSON | 9. <input type="checkbox"/> CHECK WITH MANUFACTURER |
| 3. <input type="checkbox"/> ERGONOMIC ASSESSMENT | 10. <input type="checkbox"/> DISCIPLINE OF PERSONS INVOLVED |
| 4. <input type="checkbox"/> IMPROVED PERSONAL PROTECTIVE EQUIPMENT | 11. <input type="checkbox"/> COMMUNICATION TO THE REPOSIBLE PERSON/DEPARTMENT |
| 5. <input type="checkbox"/> EQUIPMENT REPAIR OR REPLACEMENT | 12. <input type="checkbox"/> CONTACT FACILITY SERVICES |
| 6. <input type="checkbox"/> CORRECTION OF CONGESTED AREA | 13. <input type="checkbox"/> OTHER (EXPLAIN): _____ |
| 7. <input type="checkbox"/> INSTALLATION OF GUARD OR SAFETY DEVICE | |

IN ADDITION TO THE CHECKLIST, PLEASE DESCRIBE IN DETAIL CORRECTIVE MEASURES TO PREVENT RECURRENCE

PERSON RESPONSIBLE FOR ACTION: _____	COMPLETION DATE: _____
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SIGNATURES

I certify that the above information I provided is true and complete to the best of my knowledge.

PERSON INVOLVED in INCIDENT/INJURY/HAZARDOUS SITUATION (PRINT NAME)	DATED _____	SIGNATURE _____
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I certify that the above information in section 2 is true and complete to the best of my knowledge.

SUPERVISOR/EXTENSION # (PRINT NAME)	DATED _____	SIGNATURE _____
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DEPARTMENT CHAIR, MANAGER OR DIRECTOR (PRINT NAME)	DATED _____	SIGNATURE _____
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Instructions for Completing Form

The employee has the responsibility of reporting incidents promptly. The employee and the supervisor must fill out this form and the employee, supervisor and department chair, manager or director must sign it. The supervisor is responsible for investigating the accident and for ensuring corrective action to prevent a recurrence of the incident for due diligence purposes. If personal injury is involved, all appropriate procedures must be followed (please refer to RMM 1000 and 1002). The report must be forwarded immediately to Environmental and Occupational Health Support Services by email at ehss@mcmaster.ca, or for areas in the Faculty of Health Sciences, forward to the Faculty of Health Sciences Safety Office by email to fhss@mcmaster.ca. If you require additional assistance, please contact Environmental & Occupational Health Support Services at ext. 24352 or the Faculty of Health Sciences Safety Office at ext. 24956.

TYPES OF INCIDENTS TO REPORT

HAZARDOUS SITUATION – Refers to an incident caused by an unsafe act, an unsafe condition or a combination of both in the work environment which could have resulted in property loss and/or physical harm.

FIRST AID INJURY – An injury of such minor nature that treatment can be carried out by application of a band aid, cold compress or any other content of a first aid kit.

HEALTHCARE INJURY – An incident which requires treatment or service rendered by a health care professional but does not result in time lost from work other than the day of injury.

LOST TIME INJURY – Refers to an injury which results in time lost from work **beyond the day** of the injury.

BLOOD / BODY FLUID EXPOSURE – Refers to exposure to body fluids with the capability of transmitting disease organisms, i.e. blood, seminal fluid, vaginal secretions, cerebral spinal fluid, synovial fluid, pleural fluid, peritoneal fluid, pericardial fluid, amniotic fluid and tissues.

Critical Injury is defined as an injury of a serious nature that:

- places life in jeopardy;
- produces unconsciousness;
- results in substantial loss of blood;
- involves the fracture of a leg or arm, but not a finger or toe;
- involves the amputation of a leg, arm, hand or foot, but not finger or toe;
- consists of burns to a major portion of the body; or
- causes the loss of sight in an eye.

In the case of a critical injury, supervisors are responsible for:

1. Securing the accident site and ensure that further injury is prevented.
2. Immediately arranging for medical and emergency assistance by call Security at “88” or “5555” at host hospitals and “911” at any other off-campus locations.
3. Immediately notifying Environmental and Occupational Health Support Services at ext. 24352 and communicate details of the incident.
4. Ensure that the site remains undisturbed until Environmental and Occupational Health Support Services provide clearance.
5. Cooperating with directives from Environmental and Occupational Health Support Services and the Ministry of Labour.

RESPONSIBILITIES

Employee Responsibilities

1. Promptly receive appropriate medical treatment.
2. Notify supervisor as soon as possible of injury and any related healthcare.
3. Assist with the completion of Injury/Incident form and sign it.
4. Assist in the incident investigation and implementation of any corrective action.
5. Adhere to the legal requirements of WSIB and participate in McMaster University's Return to Work Program if modified work and/or lost time results from a work related injury.

Supervisor Responsibilities

1. Ensure that the injured employee receives appropriate medical treatment in the case of personal injury.
2. Provide transportation for the injured employee to a healthcare practitioner or Emergency and provide a Functional Abilities Form.
3. Report the injury/incident to Environmental and Occupational Health Support Services or the Faculty of Health Sciences Safety Office using the Injury/Incident Form.
4. Investigate the incident as soon as possible and take corrective actions when appropriate to prevent reoccurrence.
5. Inform Environmental and Occupational Health Support Services and Employee Health Services promptly if an employee has been diagnosed with an occupational disease.
6. Inform Employee Health Services if healthcare was sought and/or employee lost time from work, of any return to work or any change in the employee's status. Contact information available at <https://hr.mcmaster.ca/about-us/our-people/>
7. If person responsible for corrective measures/completion date is unknown, the Incident/Injury report is to be submitted with this information to follow when available.
8. If the Supervisor or Department Chair, Manager or Director is unavailable to sign the injury/incident report, the report should be submitted with all available signatures and resubmitted with remaining signatures when possible.

The information gathered on this form is collected under the authority of the *McMaster University Act, 1976*. The information is used for the academic, administrative, employment-related, financial and/or statistical purposes of the University including, but not limited to, admissions; registration and maintaining records; awards and scholarships; convocation; provision of student services, including access to information systems; alumni relations; and disclosure to or on the behalf of the applicable McMaster student government. This information is protected and is being collected pursuant to section 39(2) and section 42 of the *Freedom of Information and Protection of Privacy Act of Ontario (RSO 1990)*.

Questions regarding the collection or use of this personal information should be directed to the University Secretariat, Gilmour Hall, Room 210, McMaster University.

In addition to collecting personal information for its own purposes, McMaster University collects specific and limited personal information on behalf of the McMaster Student Union, the McMaster Association of Part-time Students and/or the McMaster Graduate Students Association. The groups use the information for the purpose of membership, administration, elections, annual general meetings, health plans and other related matters only. Please contact the relevant Student Union/Association office if you have questions about this collection, use and disclosure of your personal information.