McMaster University

Injury / Incident Report

☐ NO INJURY	☐ INJURY
☐ Hazardous Situation	☐ First Aid ☐ Healthcare ☐ Blood/Body Fluid Exposure ☐ Lost Time ☐ Critical Injury ☐ No First Aid

INSTRUCTIONS ON PAGE 3

IMPORTANT – IF PERSONAL INJURY IS INVOLVED, FORM MUST BE FAXED WITHIN 24 HRS. OF THE INCIDENT TO EITHER ENVIRONMENTAL & OCCUPATIONAL HEALTH SUPPORT SERVICES (FAX# 905.540.9085, GH 304) OR FACULTY OF HEALTH SCIENCES SAFETY OFFICE (FAX# 905.528.8539, HSC 1J11)

SECTION 1: TO BE COMPLETED BY INDIVIDUAL REPORTING INCIDENT

To be completed by Individual Reporting Incident

LAST NAME	**FIRST NAME**	**EMPLOYEE ID/STUDENT ID** (if applicable)
DEPARTMENT/UNIT	**EXTENSION**	Occupation at the time of injury: _____ Years of service to McMaster in occupation: _____

AFFILIATION ☐ EMPLOYEE ☐ STUDENT ☐ OTHER (Please specify): _____

UNION/EMPLOYEE GROUP ☐ CUPE ☐ CAW ☐ IUOE ☐ MUFA ☐ TMG ☐ SEIU ☐ CASUALS ☐ MUALA ☐ OTHER

DD/MM/YY OF INCIDENT	TIME OF DAY ☐ AM ☐ PM	**DD/MM/YY REPORTED**	TIME OF DAY ☐ AM ☐ PM

DESCRIPTION OF INCIDENT

INCIDENT LOCATION: BLDG. NAME _____ ROOM # _____

STATE EXACTLY THE SEQUENCE OF EVENTS LEADING UP TO THE INCIDENT:

(1) WHAT WERE YOU DOING AND DESCRIBE THE EFFORT INVOLVED?

(2) SIZE, WEIGHT AND TYPE OF EQUIPMENT OR MATERIALS INVOLVED (IF APPLICABLE)

(3) WHAT HAPPENED TO CAUSE THE INJURY?

(4) WHAT CONDITIONS ATTRIBUTED TO THE INCIDENT/ACCIDENT?

(5) HOW COULD THE EVENT HAVE BEEN AVOIDED?

☐ ADDITIONAL INFORMATION ATTACHED

NAME AND ADDRESSES OF WITNESSES

AREA OF INJURY **(Check all that apply)**

☐ EYES ☐ HEAD ☐ ARMS ☐ CHEST ☐ INTERNAL
☐ BACK ☐ HANDS ☐ LEGS ☐ FEET ☐ NECK

DOMINANT HAND ☐ LEFT ☐ RIGHT

TYPE OF INJURY **(Check all that apply)**

☐ ABRASION/CONTUSION ☐ BURN ☐ LOSS OF CONSCIOUSNESS ☐ SPRAIN/STRAIN
☐ ALLERGIC REACTION ☐ CUT/LACERATION ☐ MEDICAL SYMPTOMS ☐ OTHER _____
☐ ANIMAL/INSECT BITE ☐ GRADUAL ONSET ☐ PUNCTURE/NEEDLESTICK

NAME OF ATTENDING PHYSICIAN (To be completed only if healthcare obtained)

_____

TEL: _____ DATE OF HEALTHCARE: _____

TREATMENT OF INJURY

☐ EMPLOYER PHYSICIAN ☐ EMERGENCY ☐ NONE
☐ FAMILY PHYSICIAN ☐ WALK-IN CLINIC
☐ OTHER (Please specify) _____

SIGNATURES

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

PERSON REPORTING INCIDENT (PRINT NAME)	DATED	SIGNATURE
_____	_____	_____

ABOVE INFORMATION TO BE USED FOR COMPLETION OF WSIB CLAIM FORM #7

PLEASE PROVIDE A COPY TO: ☐ Department Chair, Manager or Director ☐ Environmental & Occupational Health Support Services ☐ Employee/Other

HR/Rev Dec 2011

RETURN TO: EOHSS, GH 304 (Fax# 905.540.9085) OR HEALTH SCIENCES SAFETY, HSC 1J11 (Fax# 905.528.8539)

SECTION 2: TO BE COMPLETED BY SUPERVISOR

To be completed by Supervisor

CONTRIBUTING FACTORS

WHAT CONDITIONS CONTRIBUTED TO THE INCIDENT (✓) (Check all that apply).

1 ☐ OPERATING WITHOUT AUTHORITY
2 ☐ FAILURE TO LOCK OUT
3 ☐ INSUFFICIENT TRAINING
4 ☐ UNSAFE EQUIPMENT/POOR DESIGN
5 ☐ IMPROPER POSITION OR POSTURE
6 ☐ FAILURE TO USE PERSONAL PROTECTIVE DEVICES
7 ☐ NOT GUARDED OR IMPROPERLY GUARDED
8 ☐ INADEQUATE ILLUMINATION
9 ☐ FIRE, EXPLOSION HAZARD
10 ☐ POOR HOUSKEEPING
11 ☐ UNSAFE PRACTICE
12 ☐ HAZARDOUS ENVIRONMENTAL CONDITION
13 ☐ DISTRACTING, TEASING, WILLFUL MISCONDUCT
14 ☐ INCLEMENT WEATHER
15 ☐ OTHER (EXPLAIN)

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 ☐ REINSTRUCTION OF PERSON INVOLVED
2 ☐ REASSIGNMENT OF PERSON
3 ☐ ERGONOMIC ASSESSMENT
4 ☐ IMPROVED PERSONAL PROTECTIVE EQUIPMENT
5 ☐ EQUIPMENT REPAIR OR REPLACEMENT
6 ☐ CORRECTION OF CONGESTED AREA
7 ☐ INSTALLATION OF GUARD OR SAFETY DEVICE
8 ☐ ACTIONS TO IMPROVE WORK PROCEDURE
9 ☐ CHECK WITH MANUFACTURER
10 ☐ DISCIPLINE OF PERSONS INVOLVED
11 ☐ COMMUNICATION TO THE REPONSIBLE PERSON/DEPARTMENT
12 ☐ OTHER (EXPLAIN)

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

PERSON RESPONSIBLE FOR ACTION:	COMPLETION DATE:

LOST TIME INCIDENT ONLY

Scheduled Shift on Day of Injury	Date/Time Last Worked	Date/Time Returned to Work	Regular Days & Hours of Work: S M T W Th F Sa
			___ ___ ___ ___ ___ ___ ___

SIGNATURES

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

SUPERVISOR / EXTENSION # (PRINT NAME)	DATED	SIGNATURE

DEPARTMENT HEAD (PRINT NAME)	DATED	SIGNATURE

ABOVE INFORMATION TO BE USED FOR COMPLETION OF WSIB CLAIM FORM #7

PLEASE PROVIDE A COPY TO: ☐ Department Chair, Manager or Director ☐ Environmental & Occupational Health Support Services ☐ Employee/Other

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RETURN TO: EOHSS, GH 304 (Fax# 905.540.9085) OR HEALTH SCIENCES SAFETY, HSC 1J11 (Fax# 905.528.8539)

Instruction for Completing Form

The employee has the responsibility of reporting incidents promptly. The employee and the supervisor must fill out the designated portions of this form and the employee, supervisor and department head (chair, director, etc.) 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 at 905.540.9085, or for areas in the Faculty of Health Sciences, forward to the Safety Office at 905.528.8539. If you require additional assistance, please contact Environmental & Occupational Health Support Services at ext. 24352 or the 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 at ext. 23564 / 23454 if healthcare was sought and/or employee lost time from work, of any return to work or any change in the employee's status.
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 Head is unavailable to sign the injury/incident report, the report should be submitted with all available signatures and resubmitted with remaining signatures when possible.
