Northern Ontario School of Medicine
École de médecine du Nord de l'Ontario

INJURY/INCIDENT REPORTING FORM

Section A – Employees

All employees must complete and submit this form to their supervisor as soon as possible following an injury or incident. If the employee is unable to complete this form, the supervisor must do so on their behalf. Please see the document titled "Injury/Incident Report Form Information Sheet" for assisting in completing this form.

Last Name: _____ First Name: _____
Job Title: _____ Unit: _____
Extension: _____ Email: _____
Supervisor: _____
DD/MM/YY of Injury/Incident: _____ Time of Day: _____ ☐ AM ☐ PM
Injury/Incident Location (Campus): _____ Room Number/Location: _____

Description of Injury/Incident

Briefly describe the injury/incident (include all relevant information)

Who was the injury/incident reported to? (Name and Position): _____

Phone Number: _____

DD/MM/YY Reported: _____ Time of Day: _____ ☐AM ☐ PM
Witnesses? If so, please provide names & contact information : _____

Type of injury: ☐ Incident (Near Miss) ☐ First Aid ☐ Health Care (Medical Aid) ☐ Critical Injury ☐ Occupational Illness ☐ Lost Time Injury ☐ Violence/Threat of Violence

If lost time injury, indicate DD/MM/YY last worked: _____ Time of Day: ☐ AM ☐ PM
DD/MM/YY Returned to Work: _____ Time of Day: ☐ AM ☐ PM

Indicate the injured body part, and if it was the Left, or Right, or Both Sides:

☐ Head ☐ Left ☐ Right ☐ Both	☐ Neck ☐ Left ☐ Right ☐ Both	☐ Wrist ☐ Left ☐ Right ☐ Both	☐ Lower Back ☐ Left ☐ Right ☐ Both	☐ Knee ☐ Left ☐ Right ☐ Both
☐ Face ☐ Left ☐ Right ☐ Both	☐ Shoulder ☐ Left ☐ Right ☐ Both	☐ Hand ☐ Left ☐ Right ☐ Both	☐ Abdomen ☐ Left ☐ Right ☐ Both	☐ Lower Leg ☐ Left ☐ Right ☐ Both
☐ Eye ☐ Left ☐ Right ☐ Both	☐ Upper Arm ☐ Left ☐ Right ☐ Both	☐ Finger(s) Please Specify:	☐ Hip ☐ Left ☐ Right ☐ Both	☐ Ankle ☐ Left ☐ Right ☐ Both
☐ Teeth ☐ Left ☐ Right ☐ Both	☐ Elbow ☐ Left ☐ Right ☐ Both	☐ Chest ☐ Left ☐ Right ☐ Both	☐ Pelvis ☐ Left ☐ Right ☐ Both	☐ Foot ☐ Left ☐ Right ☐ Both
☐ Ear ☐ Left ☐ Right ☐ Both	☐ Lower Arm ☐ Left ☐ Right ☐ Both	☐ Upper Back ☐ Left ☐ Right ☐ Both	☐ Upper Leg ☐ Left ☐ Right ☐ Both	☐ Toe(s) Please specify:

☐ Other (please specify): _____

Did you receive health care for your injury?
☐ Yes ☐ No

Date of Health Care received:

If yes, include the health professional's name, address and phone number:
Name: _____
Address: _____
Phone:

Treatment of injury by/at:
☐ Family Physician | ☐ Emergency Department | ☐ Health Services | ☐ Hospital | ☐ Health Professional | ☐ Clinic | ☐ Other:

_____ _____
Employee Signature Date

Section B – Supervisors

Section B must be completed and submitted (along with Section A) to Human Resources by the supervisor within 24 hours of learning of the injury/incident. See the document "Injury/Incident Report Form Information Sheet" for assistance in completing the form or contact the Human Resources Unit.

Note: Failure to submit the form within 24 hours of the injury/incident may result in the unit being charged a late reporting fine as imposed by the Workplace Safety and Insurance Board (WSIB).

Supervisor Name: _____ Unit/Portfolio: _____ Extension: _____

Contributing Factors – Check all that Apply

- ☐ Awkward Positioning/Posture (ergonomics)
- ☐ Slip/Trip/Fall (include description of footwear): _____
- ☐ Improperly Guarded Equipment/Machinery
- ☐ Failure to use Personal Protective Equipment
- ☐ Unsafe Practice
- ☐ Poor Housekeeping
- ☐ Insufficient Training
- ☐ Unsafe Equipment/Machinery
- ☐ Deviation from Safe Practice/Procedure
- ☐ Failure to Lockout
- ☐ Incorrect/Defective Tool(s)
- ☐ Other: _____

Detailed Explanation of Contributing Factor(s):

Details of Property Damage, if Applicable:

Corrective Measures – Check all that Apply

- ☐ Additional/Refresher Training
- ☐ Equipment Repair/Replacement
- ☐ Conduct Job Safety Analysis
- ☐ Improve Housekeeping
- ☐ Install Guard/Safety Device
- ☐ Discuss during Employee Orientation
- ☐ Review Personal Protective Equipment
- ☐ Change to Work Procedure
- ☐ Other (Please Explain):

Detailed explanation of corrective measure(s) taken to prevent reoccurrence:

Supervisor Signature _____ Date _____

Human Resources Signature _____ Date _____

COMPLETED FORMS MUST BE SENT TO HUMAN RESOURCES:

EMAIL: hr@nosm.ca

FAX: (705) 671-3880