

Please specify if the following report is an	<input type="checkbox"/> Injury	<input type="checkbox"/> Incident	<input type="checkbox"/> Near Miss
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**Faculty, Staff or Student Involved in the Injury/Incident/Near Miss**

Surname:	Given Name:	Contact Number:
Please circle one: <input type="checkbox"/> SMU Employee	<input type="checkbox"/> Student (including SMU student employee)	<input type="checkbox"/> Other/Visitor (explain)
Employee/Student ID A _ _ _ _ _	Department/Program:	

**Witness 1**

Surname:	Given Name:	Contact Number:
Please circle one: <input type="checkbox"/> SMU Employee	<input type="checkbox"/> Student (including SMU student employee)	<input type="checkbox"/> Other/Visitor (explain)

**Witness 2**

Surname:	Given Name:	Contact Number:
Please circle one: <input type="checkbox"/> SMU Employee	<input type="checkbox"/> Student (including SMU student employee)	<input type="checkbox"/> Other/Visitor (explain)

**Injury/Incident/Near Miss Information**

Date and Time: _____ am _____ pm	Location of the Injury/Incident/Near Miss:
Reported by:	

Description of Injury/Incident/Near Miss (Please describe exactly what happened and attach any pages including diagrams/pictures if necessary):

Describe any possible precipitating factors that directly contributed to the Injury/Incident:

Describe any action taken to mitigate any possible injury or further incident:

Describe any personal injury or property/equipment damage which occurred due to the Injury/Incident:

**Prevention: Are there any preventative actions which could be put in place to prevent an injury/incident like this to re-occur?**

Employee:

Supervisor:

Form Submitted by:	Date:
Reviewed by Direct Supervisor:	Date:

**If an Injury has occurred please complete the following section**

**Cause of Injury**

Slips/Trips/Falls ( )	Shock/Seizure ( )	Over Exertion/Strain ( )	Harmful Substance/Harmful Exposure ( )
Struck by Object ( )	Unknown ( )	Other ( ) (explain):	

**If Applicable Please Specify Area Injured**

Head ( )	Eyes ( )	Face ( )	Neck/Shoulders ( )	Chest ( )	Arms ( )	Hands ( )
Abdomen/Stomach ( )	Legs ( )	Feet ( )	Upper Back ( )	Lower Back ( )	Internal Injuries ( )	

Other ( ) (explain):

**Emergency Medical Attention**

Security Called	Yes	No	First Aid Given	Yes ( )	By whom:	No ( )		
911 Called	Yes	No	Transported by: Ambulance ( )	Private Vehicle ( )	Other ( )			
Sent to Hospital	Yes	No	Referred to Student Counselling	Yes	No	Referred to FEAP	Yes	No

**Treated by**

University Health Services	Yes	No	(On campus) Physiotherapy Clinic	Yes	No	Family Doctor	Yes	No
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**Occupational Health and Safety Office Use Only**

WCB Coverage	Yes	No	Form Sent to:
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