Health and Safety Injury/Incident Report

(Please print, sign, and return completed hard-copy to the Occupational Health and Safety Office)

Please specify if the following report is an	**( ) Injury**	**( ) Incident**	**( ) Near Miss**

Faculty, Staff or Student Involved in the Injury/Incident/Near Miss			
Surname:		Given Name:	Contact Number:
Please circle one:	SMU Employee	Student (including SMU student employee)	Other/Visitor (explain)
Employee/Student ID A _ _ _ _ _ _ _ _		Department/Program:	

Witness 1			
Surname:		Given Name:	Contact Number:
Please circle one:	SMU Employee	Student (including SMU student employee)	Other/Visitor (explain)

Witness 2			
Surname:		Given Name:	Contact Number:
Please circle one:	SMU Employee	Student (including SMU student employee)	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 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						
911 Called	Yes	No	First Aid Given	Yes ( )	By whom:	No ( )
Sent to Hospital	Yes	No	Transported by: Ambulance ( )		Private Vehicle ( )	Other ( )
Referred to EAP	Yes	No	Referred to Student Counselling		Yes	No

Treated by								
University Health Services	Yes	No	(On campus) Physiotherapy Clinic	Yes	No	Family Doctor	Yes	No

Occupational Health and Safety Office Use Only			
WCB Coverage	Yes	No	Form Sent to:

THIS INFORMATION IS COLLECTED FOR THE PURPOSE OF THE SAINT MARY'S OCCUPATIONAL HEALTH AND SAFETY COMMITTEE