Employee's Report of Work-Related Accident, Injury, or Illness

Section A: Employee Information

Name (Last , First, MI): ..... Phone Number: .....

Where do you work? ☐ Main Campus ☐ Off campus Department: .....

Date of incident: _____ Time incident occurred: ..... am / pm

Location of Incident: ..... Time shift started: ..... am / pm

Employment status:

☐ Faculty ☐ Regular ☐ Resident ☐ MSM Student

☐ Contractor* ☐ Child ☐ Visitor/member of public ☐ Volunteer

☐ Other: .....

* Name of contracting company: .....

Employment basis:

☐ Full-time ☐ Part-time ☐ Temporary

Section B: Incident Details

☐ Injury ☐ Work related illness ☐ Non work-related illness ☐ Property damage

☐ Dangerous event ☐ Electrical incident ☐ Environmental incident ☐ Near miss

Name of supervisor:

Name (Last , First, MI): ..... Phone Number: .....

Job Title: ..... Email address: .....

Incident occurred while:

☐ At work ☐ Travelling to/from work ☐ Meal break ☐ Other

Date reported: ..... Reported to: .....

Exact location details: (Building/Area where incident occurred)

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What happened? (What were you doing at the time of the incident? Briefly describe how it happened.)

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Were any government agencies called to the incident? (Police, Fire Services, etc.)

☐ No ☐ Yes (if yes provide details)

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List any witnesses: (names, telephone contact details, ID No if applicable)

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Section C: Details of injured person and injury

Details of treatment required:

☐ None	☐ Self	☐ First aid **
☐ Campus Medical Centre	☐ Seen by other Medical Doctor	☐ Hospital

**Describe first aid treatment given:

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Nature of injury:

☐ Allergy or sensitivity	☐ Exposure effects heat/cold	☐ Occupational overuse injury
☐ Amputation	☐ Fainting	☐ Poisoning/toxic effects
☐ Asphyxiation	☐ Foreign body	☐ Post - traumatic shock
☐ Bruising	☐ Fracture/dislocation	☐ Psychological disorder/stress effects
☐ Burn / scalds	☐ Hearing loss	☐ Puncture
☐ Communicable disease	☐ Hernia	☐ Respiratory
☐ Concussion or other neuro injury	☐ Internal injuries	☐ Skin condition eg dermatitis/ eczema
☐ Contusion/crush	☐ Laceration/deep cut	☐ Superficial wound or abrasion
☐ Damage to artificial aids	☐ Multiple injuries	☐ Sprain/strain
☐ Electric shock or effects	☐ Nausea/vomiting	☐ Vision impairment

Part of body affected: ☐ Left ☐ Right

☐ Head	☐ Neck	☐ Forearm	☐ Chest	☐ Buttock	☐ Shin/calf
☐ Face	☐ Shoulder	☐ Wrist	☐ Back	☐ Thigh	☐ Ankle
☐ Ear	☐ Upper arm	☐ Hand	☐ Stomach / trunk	☐ Knee	☐ Foot/toe
☐ Eye	☐ Elbow	☐ Fingers/thumb	☐ Groin /hip	☐ Internal	

Were you injured? Yes ____ No____ (check one) If yes, indicate the part(s) of the body injured:_____

Additional comments:

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Agency of injury (what?)

☐ Animal/Insect	☐ Mobile plant/equipment	☐ Radiation
☐ Biological agent (eg pathogens)	☐ Needle/sharp	☐ Repetitive work
☐ Chemical	☐ Noise	☐ Situation – violence, assault
☐ Electrical	☐ Non-power tool	☐ Surface (slippery/rough)
☐ Explosion/implosion	☐ Objects	☐ Thermal (heat/cold)
☐ Lifting/ Carrying	☐ Power tools	☐ Vehicle/transport
☐ Machinery/fixed plant	☐ Psychological/social	☐ Workstation design

☐ Other (please specify): ……

Action/ mechanism which caused injury (how?)

☐ Exposure to biological material	☐ Fall from height	☐ Muscle stress – repetitive
☐ Exposure to chemicals	☐ Hit by/trapped in moving object	☐ Noise
☐ Exposure to electricity	☐ Hitting object	☐ Pressure
☐ Exposure to heat/cold	☐ Insect/animal bite	☐ Slip/trip *requires further investigation*
☐ Exposure to radiation	☐ Mental stress factors	☐ Vehicle accident
☐ Exposure to vibration	☐ Muscle stress- loads	

☐ Other (please specify): ……

Section D: Acknowledgements

Check One:

_____ I have elected ***NOT*** to seek treatment as a result of this accident.

_____ I have sought and/or will seek treatment as a result of this accident.

Employee/Claimant:

Name: ……

Signature: ……

Comments: ……

Date: …… Telephone: …… ……

Human Resources Manager:

Name: ……

Signature: ……

Comments: ……

Date: …… Telephone: …… ……