



INCIDENT INVESTIGATION REPORT

THIS FORM IS TO BE COMPLETED BY THE INJURED WORKER'S SUPERVISOR WITHIN 2 DAYS AND FAXED TO THE MANAGER, HUMAN RESOURCES/HEALTH AND SAFETY, SD 63 (SAANICH), AT 250-652-7372

This form is provided to employers for the purpose of documenting the employer's investigation into a workplace incident.

Incident Occurred *ref: s. 3.4(a) OHS Regulation*

Where incident occurred (*school name, where on property, etc*)

Date (<i>yyyy-mm-dd</i>)	Time <i>a.m.</i> <input type="checkbox"/> <i>p.m.</i> <input type="checkbox"/>
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Will the worker be away from work <u>beyond</u> the date of injury?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Has the worker seen or plan to see a qualified medical practitioner?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

Injured Person *ref: s. 3.4(b) OHS Regulation*

Last Name	First Name	Job Title	Birthdate <small>yyyy-mm-dd</small>	Employed Since	Time on present job

Nature of Injury/Injuries

- 1)
- 2)
- 3)

Witnesses *ref: s. 174(4) WCA and s. 3.4(c) OHS Regulation*

Last Name	First Name	Address	Telephone
1)			
2)			

Incident Description *ref: s. 3.4(d)-(e) OHS Regulation*

Briefly describe what happened, including the sequence of events preceding the incident.

Statement of Causes *ref: s. 174(2)(a)-(b) WCA and s. 3.4(f) OHS Regulation*

List any unsafe conditions, acts, or procedures that in any manner contributed to the incident.

Injured Person: _____ Date of Incident: _____ First Aid Record Sequence No. () _____

General Information (check all that apply)

Did the incident occur on District premises or an authorized worksite?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Did the incident happen during the worker's normal shift?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Was the worker performing their regular duties at the time of the incident?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Were the worker's actions, at the time of injury, for the purpose of District business?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

<p>Identify Incident Type (check all that apply)</p> <input type="checkbox"/> Struck against or struck by object <input type="checkbox"/> Slip, trip or fall <input type="checkbox"/> Caught in, under or between <input type="checkbox"/> Exposure to or contact with harmful substance (excluding blood/body fluids) <input type="checkbox"/> Exposure to blood or body fluids <input type="checkbox"/> Fire <input type="checkbox"/> Car or transportation accident <input type="checkbox"/> Threatening Behaviour (see Threatening Behaviour/Incident Information section) <p>Ergonomics</p> <input type="checkbox"/> Bodily reaction <input type="checkbox"/> Overexertion <input type="checkbox"/> Repetitive motion <input type="checkbox"/> Lifting/moving object: approximate weight: ____ lbs ____ kg <input type="checkbox"/> Other (specify under Statement of Causes)	<p>Identify all Contributory Factors (check all that apply)</p> <p>Equipment</p> <input type="checkbox"/> Faulty – equipment known to be faulty before incident <input type="checkbox"/> Faulty – equipment not known to be faulty before incident <input type="checkbox"/> Used for something other than its intended purpose <input type="checkbox"/> Used in accordance with manufacturer's instructions <input type="checkbox"/> Other (specify under Statement of Causes) <p>Environment</p> <input type="checkbox"/> Wet/slippery conditions <input type="checkbox"/> Over-crowding or confined working space <input type="checkbox"/> Noise <input type="checkbox"/> Lighting <input type="checkbox"/> Climate temperature <input type="checkbox"/> Property: <input type="checkbox"/> Building(s) <input type="checkbox"/> Ground(s) <input type="checkbox"/> Fencing, Irrigation, etc <input type="checkbox"/> Other (specify under Statement of Causes)
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Threatening Behaviour/Incident Information Staff/Student Involvement ONLY (NOTE: For student involvement, the "Employee Injury/Incident Student Related" Form must also be completed)

Name(s) of Person(s) causing incident:	Threatening Behaviour (check all that apply)		
	<input type="checkbox"/> Verbal abuse <input type="checkbox"/> Verbal threat <input type="checkbox"/> Written threat <input type="checkbox"/> Bullying/Intimidation <input type="checkbox"/> Students Fighting <input type="checkbox"/> Inciting Hostility	<input type="checkbox"/> Physical Assault <input type="checkbox"/> Sexual Assault <input type="checkbox"/> Intruder <input type="checkbox"/> Property Damage <input type="checkbox"/> Other:	<input type="checkbox"/> Weapon Involved <input type="checkbox"/> Police Involved <input type="checkbox"/> Family Member Involved <input type="checkbox"/> Other:
Name(s) of Staff Member(s) involved:			

Recommendations ref: s. 174(2)(c) WCA and s. 3.4(g) OHS Regulation

Identify any corrective actions that have been taken and any recommended actions to prevent similar incidents.

Recommended Corrective Action	Action by Whom	Action by Date
1)		
2)		
3)		
4)		

Person(s) Conducting Investigation ref: s 3.4(h) OHS Regulation

Name	Signature	Type of Representative	Date
		<input type="checkbox"/> Employer <input type="checkbox"/> Worker <input type="checkbox"/> Other	
		<input type="checkbox"/> Employer <input type="checkbox"/> Worker <input type="checkbox"/> Other	

Manager, Human Resources/Health and Safety's Report (fax to 250-652-7372)

Note any additional information relevant to this incident: _____

Name: _____ Signature: _____ Date: _____