

GUIDE TO COMPLETING THE INCIDENT INVESTIGATION REPORT FORM

Definitions

Incident: an unplanned event that results in, or could result in, an injury or fatality, or damage/destruction of equipment, property or the environment.

Complete this form for incidents that may result in one or more of the following:

- **Near-Miss:** an incident that does not result in an injury
- **First Aid:** treatment such as ice packs, bandages or eyewash flushing, etc.
- **Medical Aid:** treatment or examination by a physician, dentist, chiropractor, physiotherapist, emergency room attendant or similar health care practitioner
- **Lost Time:** unable to attend the next regularly scheduled shift of work
- **Critical Injury:** an injury that results in a broken bone, significant loss of blood, loss of sight, an amputation, burns to a major part of the body, unconsciousness (not due to personal health), or places life in jeopardy
- **Environmental:** the discharge of a contaminant to the natural environment (air, noise, sewage, waste)

This form can be completed **electronically** and must be sent to your Manager/Associate Dean or College Contact ASAP, so that it can be reviewed and sent to Environment, Health and Safety Services (incident@fanshawec.ca) **within 24 hours** of the incident.

All **slips and falls** should be reported immediately to the Security Control Centre at 519-452-4400.

If your injury is identified as a **critical injury** you must **immediately** report the injury to your Manager/Associate Dean.

Report **environmental incidents** immediately to the Security Control Centre at 519-452-4400.

Instructions for Person Involved in the Incident:

- Check the appropriate box under the Incident Classification section.
- Continue with relevant sections, as outlined below:
 - Employees complete Sections A, B, C, F, G, I
 - Students complete Sections A, B, D, F, G, I
 - Visitors and Contractors complete Sections A, B, E, F, G, I
- If an incident later escalates into a medical aid or lost time, you must notify your Manager/Associate Dean or College contact of this change.
- Incidents should not be reported to Team Leaders/Program Coordinators as they are not supervisors.

Instructions for Managers/Associate Deans and other College Contacts:

- Review the completed form, as submitted by the person involved in the incident.
- For Critical Injuries, immediately report injury to Security Control Centre at 4400 so EHS Services can ensure external reporting occurs.
- For Student incidents: If the student is on placement, attach the completed "Postsecondary Student Unpaid Work Placement Workplace Insurance Claim Form".
- Complete Sections H and I.
- Attach any additional information relevant to this incident (witness statements, SDS info sheets, etc)
- For guidance on completing incident investigations go to:
<https://portal.myfanshawe.ca/campuslife/healthsafety/Pages/CHSMS.aspx>

Instructions for Printing:

With the document open on your screen:

- Select the **printer icon**.
- Select the **Advanced** button, bottom left corner.
- Select **Print as Image**. Click **OK**.
- Click **Print**.

For Further Information, contact:

Environment, Health and Safety Services
Room C2006
1001 Fanshawe College Blvd, P.O. Box 7005
London, ON N5Y 5R6
E-mail: incident@fanshawec.ca



FANSHAWE

INCIDENT INVESTIGATION REPORT

Environment, Health and Safety Services - Room C2006
1001 Fanshawe College Blvd, P.O. Box 7005
London, Ontario N5Y 5R6
Incident@fanshawec.ca

Person involved: [] Employee [] Student [] Contractor [] Visitor
Sections to complete: A, B, C, F, G, I A, B, D, F, G, I A, B, E, F, G, I A, B, E, F, G, I
Manager/Associate Dean: Ensure all sections are completed, including H and I.

A. INCIDENT CLASSIFICATION

- [] First Aid (immediate, on-site care e.g. ice pack, bandage)
[] Medical Aid (examination by health care provider)
[] Lost Time (treatment, and absent from work)
[] Near Miss/Hazardous Situation (no injury/potential for injury)
[] Recurrence of previous injury

Provide claim no., if possible: _____

B. PERSONAL INFORMATION OF PERSON INVOLVED

Full Name _____
[] Male [] Female
Date of Birth (dd/Mmm/yy) _____
Address _____
Telephone _____
City _____ Province _____ Postal Code _____

C. EMPLOYEES TO COMPLETE THIS SECTION

Employee Number _____
Name of Manager/Associate Dean _____
Department _____
Job Title _____
Length of Time in Position _____
Hire Date (dd/Mmm/yy) _____
Union Member [] 109 [] 110 [] NA
Shift Worker Yes No If yes, indicate shift _____
Normal work days and hours _____

D. STUDENTS TO COMPLETE THIS SECTION

Student Number _____
Campus Location _____
Program Name _____
Program Co-ordinator _____
Was the incident program-related? Yes No
Did the incident occur on placement? Yes No If yes, is this a paid placement? Yes No
If yes, name of placement employer _____
Telephone _____

E. CONTRACTORS and VISITORS TO COMPLETE THIS SECTION

Contractor

College Contact _____

Company Name and Address _____

Visitor

Reason for being at the College _____

F. INCIDENT INFORMATION

Date of Incident (dd/mm/yy) _____ Time _____ a.m. p.m.

Date Reported (dd/mm/yy) _____ Time _____ a.m. p.m.

Reported to _____

Position _____ Telephone _____

Individual(s) witnessing or having knowledge of the incident

Location (campus/building/room/other) _____

Describe the Incident (what you were doing and what happened), and any Injuries you received

Was the Incident/Illness: Sudden Specific Gradually Occurring Over Time

Type of Incident:

- | | | | | |
|---|-------------------------------------|---|---|--------------------------------|
| <input type="checkbox"/> Cut/Scrape | <input type="checkbox"/> Slip/Trip | <input type="checkbox"/> Fall | <input type="checkbox"/> Motor Vehicle | <input type="checkbox"/> Spill |
| <input type="checkbox"/> Overexertion | <input type="checkbox"/> Repetitive | <input type="checkbox"/> Struck/Caught | <input type="checkbox"/> Fire/Explosion | <input type="checkbox"/> Noise |
| <input type="checkbox"/> Needlestick/Puncture | <input type="checkbox"/> Assault | <input type="checkbox"/> Harmful Substances | <input type="checkbox"/> Burn | <input type="checkbox"/> Odour |
| <input type="checkbox"/> Other (please specify) _____ | | | | |

Area Affected (Body Part) - Please check all that apply

- | | | | | |
|-------------------------------------|--|--|---|--|
| <input type="checkbox"/> Head | <input type="checkbox"/> Lower Back | <input type="checkbox"/> Right Elbow | <input type="checkbox"/> Right Knee | <input type="checkbox"/> Right Lower Leg |
| <input type="checkbox"/> Face | <input type="checkbox"/> Abdomen | <input type="checkbox"/> Left Wrist | <input type="checkbox"/> Left Hip | <input type="checkbox"/> Left Ankle |
| <input type="checkbox"/> Eyes | <input type="checkbox"/> Pelvis | <input type="checkbox"/> Right Wrist | <input type="checkbox"/> Right Hip | <input type="checkbox"/> Right Ankle |
| <input type="checkbox"/> Ears | <input type="checkbox"/> Left Shoulder | <input type="checkbox"/> Left Hand | <input type="checkbox"/> Left Thigh | <input type="checkbox"/> Left Foot |
| <input type="checkbox"/> Teeth | <input type="checkbox"/> Right Shoulder | <input type="checkbox"/> Right Hand | <input type="checkbox"/> Right Thigh | <input type="checkbox"/> Right Foot |
| <input type="checkbox"/> Neck | <input type="checkbox"/> Left Upper Arm | <input type="checkbox"/> Left Fingers | <input type="checkbox"/> Left Forearm | <input type="checkbox"/> Left Toes |
| <input type="checkbox"/> Chest | <input type="checkbox"/> Right Upper Arm | <input type="checkbox"/> Right Fingers | <input type="checkbox"/> Right Forearm | <input type="checkbox"/> Right Toes |
| <input type="checkbox"/> Upper Back | <input type="checkbox"/> Left Elbow | <input type="checkbox"/> Left Knee | <input type="checkbox"/> Left Lower Leg | |

Other (please specify) _____

Have you had a prior, similar problem? Please clarify.

G. FIRST AID, MEDICAL AID and LOST TIME / NO LOST TIME

Describe First Aid treatment, if applicable:

For Medical Aid and Lost Time, provide the following:

Name of attending doctor/facility _____

Address _____

Telephone (include area code) _____

Date seen (dd/Mmm/yy) _____

Date when the College learned of visit to doctor or other health care provider (dd/Mmm/yy) _____

After the date of incident, have you lost any time or earnings from your job/placement/classes? Yes No

Start date of lost time (dd/Mmm/yy) _____

Date of return (dd/Mmm/yy) _____

Returned to Regular Modified

Has an Absence Report been forwarded to HR identifying WSIB Lost Time? Yes No

H. MANAGER/ASSOCIATE DEAN INCIDENT FOLLOW-UP and ACTION PLAN

What were the causes of this incident? (Consider contributing factors, conditions, unsafe acts, personal/job factors.)

Was personal protective equipment used at the time? Please clarify.

Was property damaged (vehicle/equipment/materials)? Please clarify.

Manager/Associate Dean Action Plan (Describe action to be taken and any recommendations.) 1.

2. _____

3. _____

Manager/Chair Responsible _____

Date (dd/mm/yy) _____

I. SIGNATURES - E-mail completed document, within 24 hours of the incident, to:

1) EHS Services (Incident@fanshawec.ca) 2) Manager/Associate Dean and/or Designate 3) Person Involved

(Note: signature is NOT required if form is completed electronically, and a copy is e-mailed to person involved and his/her manager)

Person Involved (print clearly) _____

Signature _____

Date (dd/Mmm/yy) _____

Manager/Associate Dean or College Contact (print clearly) _____

Signature _____

Date (dd/Mmm/yy) _____

FOR OFFICE USE ONLY:

Reviewed by EHSS (print clearly) _____

Date (dd/Mmm/yy) _____

Signature _____