

Personal Injury Hazard Near miss Security/Violence Environmental Workplace Illness Fire Alarm

Personal Information

Person's last name	First name	Date of Birth:	Gender <input type="checkbox"/> M <input type="checkbox"/> F
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1. What is the person's occupation?	2. Has this person been employed or studying at TRU for less than 12 months? Yes <input type="checkbox"/> No <input type="checkbox"/>	3. If yes, start date (mm/dd/yyyy)
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4. At the time of injury, the person was (check all that apply)
 Full time Part time Student Apprentice/Practicum Auxiliary Contractor Visitor

5. Location of Incident – check one:

Animal Health <input type="checkbox"/>	A&E <input type="checkbox"/>	BCCOL <input type="checkbox"/>	TRU Campus <input type="checkbox"/>	CAC <input type="checkbox"/>	Clock Tower <input type="checkbox"/>	Culinary Arts <input type="checkbox"/>	Gymnasium <input type="checkbox"/>	House of Learning <input type="checkbox"/>	Human Resources <input type="checkbox"/>
Facilities <input type="checkbox"/>	International <input type="checkbox"/>	Library <input type="checkbox"/>	Old Main <input type="checkbox"/>	Science <input type="checkbox"/>	Trades <input type="checkbox"/>	Warehouse <input type="checkbox"/>	Off Campus <input type="checkbox"/>	Williams Lake <input type="checkbox"/>	Regional Centers <input type="checkbox"/>

School/Department:

Incident Information (Employee to complete)

6. Date of Incident	Time of Incident: <input type="checkbox"/> am <input type="checkbox"/> pm	Did the person report the incident? Yes <input type="checkbox"/> No <input type="checkbox"/>
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7. Name person reported to: First Aid: Supervisor: Instructor: Other:

8. Describe how the incident happened?	9. Describe the injury in detail:
10. Side of body injured <input type="checkbox"/> Left <input type="checkbox"/> Right <input type="checkbox"/> Both <input type="checkbox"/> Not Applicable	

11. Severity of injury/ incident

<input type="checkbox"/> Insignificant	No treatment ; no damage ; no disruption of services
<input type="checkbox"/> Minor	First Aid treatment (Minor cuts, bruises, irritations, burns); Minor damage; No disruption of services
<input type="checkbox"/> Moderate	Disabling injury, reversible tissue damage (Medical treatment); Damage up to \$999; Minimal disruption of services
<input type="checkbox"/> Major	Extremely serious injury (Permanent disability);Damage \$1000 to \$99,999; Major disruption of services
<input type="checkbox"/> Fatality	Damage \$100,00 to \$499,999; Extensive disruption of services

12. Contributing factors – select at least one, and as many as applicable:

<input type="checkbox"/> Lifting Lb Kg	<input type="checkbox"/> Struck	<input type="checkbox"/> Assault
<input type="checkbox"/> Overexertion	<input type="checkbox"/> Crush	<input type="checkbox"/> Motor vehicle accident
<input type="checkbox"/> Repetitive (activity repeated over and over again)	<input type="checkbox"/> Sharp edge	<input type="checkbox"/> Hazardous Spill
<input type="checkbox"/> Slip or trip	<input type="checkbox"/> Fire or Explosion	<input type="checkbox"/> Other:
<input type="checkbox"/> Twist	<input type="checkbox"/> Animal bite	

13. Did person receive first aid treatment? <input type="checkbox"/> Yes <input type="checkbox"/> No Date: (mm/dd/yyyy)	If Yes, please provide first aid attendants name.
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14. Did the person go to the hospital, clinic, or doctor? <input type="checkbox"/> Yes <input type="checkbox"/> No Date: (mm/dd/yyyy)	If Yes, Please provide doctors name and location
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Corrective Actions: (Supervisor to complete)

Hierarchy of Control	Action Taken/ Recommended	Whom	When
1. Elimination 2. Substitution (use an alternative) 3. Isolate (separation from hazard) 4. Redesign (change equip/process) 5. Administration (change work practice) 6. Personal Protective Equipment (gloves, glasses, hearing protection)			

Supervisor/Instructor Signature and report date

15. Supervisor/Instructor Name	16. Title	17. Date of Report
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