Submit

THOMPSON RIVERS UNIVERSITY | Safety & Emergency Management

Incident Report Form

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

Personal Information

Person's last name	**First name**	**Date of Birth:**	**Gender** ☐ **M** ☐ **F**

1. What is the person's occupation?	**2.** Has this person been employed or studying at TRU for less than 12 months? Yes ☐ No ☐	**3.** If yes, start date (mm/dd/yyyy)

4. At the time of injury, the person was (check all that apply)

☐ Faculty ☐ Admin ☐ CUPE ☐ Student ☐ Apprentice/Practicum ☐ Auxiliary ☐ Contractor ☐ Visitor

5. Location of Incident – check one:

Animal Health ☐	A&E ☐	BCCOL ☐	TRU Campus ☐	CAC ☐	Clock Tower ☐	Culinary Arts ☐	Gymnasium ☐	House of Learning ☐	Human Resources ☐
Facilities ☐	International ☐	Library ☐	Old Main ☐	Science ☐	Trades ☐	Warehouse ☐	Off Campus ☐	Williams Lake ☐	Regional Centers ☐

School/Department:

Incident Information (Employee to complete)

6. Date of Incident	**Time of Incident:** ☐ **am** ☐ **pm**	**Did the person report the incident?** Yes ☐ No ☐

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 ☐ **Left** ☐ **Right** ☐ **Both** ☐ **Not Applicable**

11. Severity of injury/ incident

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

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

☐ Lifting Lb Kg
☐ Overexertion
☐ Repetitive (activity repeated over and over again)
☐ Slip or trip
☐ Twist
☐ Struck
☐ Crush
☐ Sharp edge
☐ Fire or Explosion
☐ Animal bite
☐ Assault
☐ Motor vehicle accident
☐ Hazardous Spill
☐ Other:

13. Did person receive first aid treatment? ☐ Yes ☐ No Date: (mm/dd/yyyy)	If Yes, please provide first aid attendant's name.
14. Did the person go to the hospital, clinic, or Health Care Provider? ☐ Yes ☐ No Date: (mm/dd/yyyy)	If Yes, Please provide Health Care Provider's name and location

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**