



EMPLOYEE ACCIDENT/INCIDENT REPORT

PLEASE CONTACT THE HEALTH AND SAFETY OFFICER (KEN JONES) IMMEDIATELY AT 735-1031 FOR ALL ACCIDENTS

Name of employee: _____

Address: _____ D.O.B. _____
_____ P.C. _____ Tel. # _____
dd/mm/yy

Date of hire if known: _____
dd/mm/yy

Workplace / School: _____ Position Occupied: _____

Normal working hours: _____ Part time: _____ Full Time: _____

Date of accident/incident: _____ Time of accident/incident: _____

Was the employee absent from work beyond the day of the injury: Yes No Dates: _____

Date and hour last worked: _____ Time: _____

Date accident reported to Immediate Supervisor / Department Head: _____ Time: _____

Name of person accident/incident reported to: _____

What happened to cause the injury? _____

What was the employee doing during the time of accident/incident? _____

Identify the size, weight and type of equipment or materials involved (if applicable): _____

In what specific area did the accident/incident occur? _____

Describe the injury, part of the body involved, and specify left or right side: _____

Did the employee go to the hospital or seek medical attention? Yes No When? _____

Name of hospital or clinic: _____ Name of attending physician: _____

Was first-aid administered? Yes No If yes, by whom? _____

Name of witness who saw the accident/incident: _____

Employee's signature: _____

- N.B. 1. PLEASE FORWARD THIS FORM BY FAX THE DAY OF THE ACCIDENT/INCIDENT (FAX # 735-1715)
2. PLEASE ENSURE THAT THE PROPER EMERGENCY CARE IS PROVIDED**