



Injury (Accident) / Incident/ Illness/ Hazard Report

Submit to: Environmental Health & Safety Office
Via internal mail to GM-1100-50 or Fax to Ext. 2807

FOR OFFICE USE: Ref. #: _____ A I P H O

cc. Supervisor: _____ Safety Officer: _____ Union Rep.: _____
H&S Committee: _____ EHS: _____ Other: _____

1. EVENT TYPE:

- Injury Incident (no injury) Illness Hazard

Date of event (m/d/yy): _____ Time: _____ am pm

Brief description of event / hazard : _____

If any corrective measures have been taken or are required, please explain... _____

2. VICTIM OR COMPLAINANT INFORMATION:

Family Name: _____ First Name: _____ Age: _____

Home telephone: _____ Office telephone: _____

Home address: _____
No. Street Apt. # City Postal Code

Sex: Female Male

ID # : _____

Status: (At the time of event)

- Full-time Employee Undergraduate Student
 Part-time Employee Graduate Student
 Contract Employee External Contractor
 Visitor

Department: _____

Supervisor (if applicable): _____

Union/Association (if applicable): _____

3. EVENT LOCATION:

Campus: SGW LOY

Building: _____

Room Number: _____

Location: (Please check one, if other specify):

- | | | |
|---|---|---|
| <input type="checkbox"/> office | <input type="checkbox"/> doorway | <input type="checkbox"/> roof |
| <input type="checkbox"/> classroom | <input type="checkbox"/> auditorium | <input type="checkbox"/> washroom |
| <input type="checkbox"/> laboratory | <input type="checkbox"/> outdoors on campus | <input type="checkbox"/> eating areas |
| <input type="checkbox"/> library | <input type="checkbox"/> construction site | <input type="checkbox"/> residence |
| <input type="checkbox"/> corridor/hallway | <input type="checkbox"/> stairs / elevator | <input type="checkbox"/> bar |
| <input type="checkbox"/> gym / field / ice rink | <input type="checkbox"/> parking lot | <input type="checkbox"/> other: (specify) _____ |
| <input type="checkbox"/> loading dock | <input type="checkbox"/> outdoors off campus | |
| <input type="checkbox"/> boiler/mechanical room | <input type="checkbox"/> Facilities Management/ IITS shop | |
| <input type="checkbox"/> entire building | <input type="checkbox"/> academic workshop / studio | |

4. INJURY: yes no (if no, sign and complete form)

Type of Injury: _____

Body part injured: _____

Type of treatment : None First-aid on site Health Services Family Doctor Clinic Hospital

Treatment administered by: _____ Date of treatment (m/d/yy): _____

Transportation recommended: no yes → If yes: Ambulance Taxi Car

Transportation refused: no yes → If yes, state reason: _____

Employees only: Consequence of Injury (check one):

- No First-Aid administrated, return to work
- First-Aid administrated, return to work
- Saw a physician, return to work
- Saw a physician, return to work, light duty
- Saw a physician, time loss
- Refused medical treatment

If there was time loss from work, please indicate how long: _____

Signature: _____ Date (m/d/yy): _____

If the victim is unable to complete the Injury (Accident) / Incident / Illness / Hazard Report, the event should be reported by a witness or a supervisor.

Reported by: _____ Date (m/d/yy): _____

Department: _____ Tel. : _____