INCIDENT REPORT FORM

To be completed for all injuries, incidents, and near misses.

REPORT # 683873

CONTACT INFORMATION:

Name of Reporting Person(s):

Telephone #: Email Address:

Name of Affected Person(s) (if different than above):

Title of Affected Person(s): ☐ StMU Employee ☐ Student ☐ Visitor ☐ Contractor

Type of Occurrence: ☐ Incident ☐ Near Miss ☐ Hazard ☐ First Aid Injury
☐ Medical Aid ☐ Occupational Illness

DETAILS OF THE OCCURANCE:

Date of Occurrence: Time:

Date of Report: Time

Location of Occurance (Building/Room #):

Description of Occurrence:
(What happened to cause the accident/incident? What was the person doing? Was there any people/equiptment/materials involved? Describe the size, weight, and/or type. Please use the back of this page if more space is needed)

IMMEDIATE CORRECTIVE ACTIONS TAKEN:

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PEOPLE INVOLVED/WITNESSES:

Name: Witness Statement Attached Yes ☐ No ☐

Name: Witness Statement Attached Yes ☐ No ☐

ADDITIONAL INFORMATION:

Was First Aid necessary? ☐ Yes ☐ No

If yes, who administered First Aid?

Did the injured person require medical attention? ☐ Yes ☐ No

If yes, how was the person transported? ☐ Ambulance ☐ Personal Vehicle ☐ Other

For employees, can this person continue to work? ☐ Yes ☐ No

If no, date and time last worked:

ANY INCIDENT RESULTING IN HOSPITALIZATION MUST BE REPORTED TO OHS

Signature of Reporter: _____ Signature of Manager/VP/Dean: _____
Date:_____ Date: _____

Signature of Director of Facilities: _____
Date: _____