INCIDENT REPORT & INVESTIGATION FORM

Section 1 – Affected Individual's Information

Please PRINT

First Name	Last Name	Date of Birth
		dd / mm / yyyy

Home Address *(include street number, street name, apt no.(if applicable), city, province and postal code)*	Home Telephone / Cell Phone Number	Work Extension

Occupation and Department at College (*Employee*)	Age	Gender	Employee	Student	Public	Contractor
		M ☐ F ☐	☐	☐	☐	☐

Student ID OR Employee ID Number	Program at College (*Student*)	Reason on Campus (*public or contractor*)

Section 2 – Incident Information

Location of Incident *(Campus or Off-site Location, Room #, Staircase location, Parking Lot information)*	Date of Incident dd / mm / yyyy	Time of Incident hh:mm
		☐ AM ☐PM

Was the accident / illness:	Type of incident (*Please check all that apply*)		
☐ Sudden Specific Event/Occurrence	☐ Laceration/Cut	☐ Slip or Fall	☐ Bruise
☐ Gradually Occurring Over Time	☐ Overexertion (strain/sprain)	☐ Harmful Substance/Environmental	☐ Motor Vehicle Incident
☐ Occupational Disease	☐ Repetitive Injury	☐ Assault	☐ Needle Stick
	☐ Burn	☐ Other	☐ Bodily Fluid Splash

Area of Injury - Please check all that apply:

			Left / Right	Left / Right	Left / Right	Left / Right
☐ Head	☐ Teeth	☐ Upper back	☐ Shoulder ☐	☐ Wrist ☐	☐ Hip ☐	☐ Ankle ☐
☐ Face	☐Neck	☐ Lower back	☐ Arm ☐	☐ Hand ☐	☐ Thigh ☐	☐ Foot ☐
☐ Eye(s)	☐ Chest	☐ Abdomen	☐ Elbow ☐	☐ Finger(s) ☐	☐ Knee ☐	☐ Toe(s) ☐
☐Ear(s)		☐ Pelvis	☐ Forearm ☐		☐ Lower Leg ☐	
☐Other						

Section 2 - Incident Information Continued

Description of Incident *(Describe what happened to cause the incident and what the worker/student was doing at the time. Detail what the injury is and any other contributing factors to the incident.)*

Type of Care Provided:		
First Aid at College Health Center ☐	Health Care College Health Care Center ☐	EMS Called ☐
First Aid by Dept. First Aid Delegate ☐	Health Care at Clinic ☐ Clinic Information	4911 or 3911 Activated ☐
First Aid by Security ☐	Health Care at Hospital ☐ Hospital Information	Near Miss ☐
First Aid by Other ☐ Specify Other		WSIB Reportable ☐
	Health Care at Practitioner's Office ☐ Practitioner's Name and Phone Number	Critical Injury ☐

Section 3 – Reporting Individual's Information

Name of Person The Incident Was Reported To:	**Home Telephone / Cell Phone Number**	**Work Number**
Occupation and Department at College		**Manager / Chair of Area**

Reported to College Personnel (*if significantly different from time incident occurred, please provide explanation*)		**Witness information**	
Date	**Time**	**Name of Witness**	**Phone Number of Witness**
dd / mm / yyyy	hh:mm ☐ AM ☐ PM		

Section 4 – Incident Investigation

Root Cause – What substandard actions and conditions caused or could cause the event? Were there any contributing factors?

Witness Accounts	
Name of Witness	**Witness Account** *(if more room is required, please attach a separate piece of paper)*

Have there been prior similar incidents? Yes ☐ No ☐

Immediate Steps Taken To Prevent A Recurrence	**Person Responsible**	**Date Completed**
1.		
2.		
3.		
Further Action Recommended *(Complete an Incident Recommendation Follow-up Form)*	**Person Responsible**	**Timeline for Completion**
1.		
2.		
3.		

Section 5 – Authorization

Signature of Injured Person (if possible)	Print Name	Day Month Year Date:
Signature of Incident Investigator (Faculty/ Manager/ Security/ OHS)	Print Name	Day Month Year Date:
Signature of Manager or Chair of School (if not the Investigator)	Print Name	Day Month Year Date:
Signature of Occupational Health and Safety Designate	Print Name	Day Month Year Date:

Email, fax or send to Safety, Security & Facilities Management Department within 24 hours.

Tel: 519-972-2727 ext. 4556 or 4569 Fax: 519-972-2752 **SECURITY (evenings & weekends):**
Justin Martin jmartin@stclaircollege.ca Email: securitysouth@stclaircollege.ca
Naz Binck: nbinck@stclaircollege.ca

PLEASE NOTE: *The information on this Incident Report Form may be provided to the College's Insurance Carrier. If you would like a copy of this incident report, please contact the Safety, Security & Facilities Management Department.*

Incident Recommendation Follow-up Form
(To be completed by Manager/Chair of Area)

Incident	
Affected Individual	
Incident Date	

Further Recommended Action	Person Responsible	Date Completed
1.		
2.		
3.		
4.		

St. Clair College – Aquatic Services

Incident Report Attachment Sheet

Follow Up Form

Name of Victim: ID# *(if available)*:	Date of Incident:
Nature of Incident:	Time of Incident:
	Duration of Incident:

Person contacted:	Contact Phone #:	Date of Follow up:
Relationship to Victim:	Start & End Time of Phone Call:	

Please indicate what was discussed in the follow up conversation:

_____
_____
_____
_____
_____
_____
_____
_____
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_____
_____
_____
_____
_____
_____

Was the person involved seen by a doctor?	YES	NO
Will they require a copy of the incident report?	YES	NO
Is any further action required?	YES	NO

Copies of Report sent to:

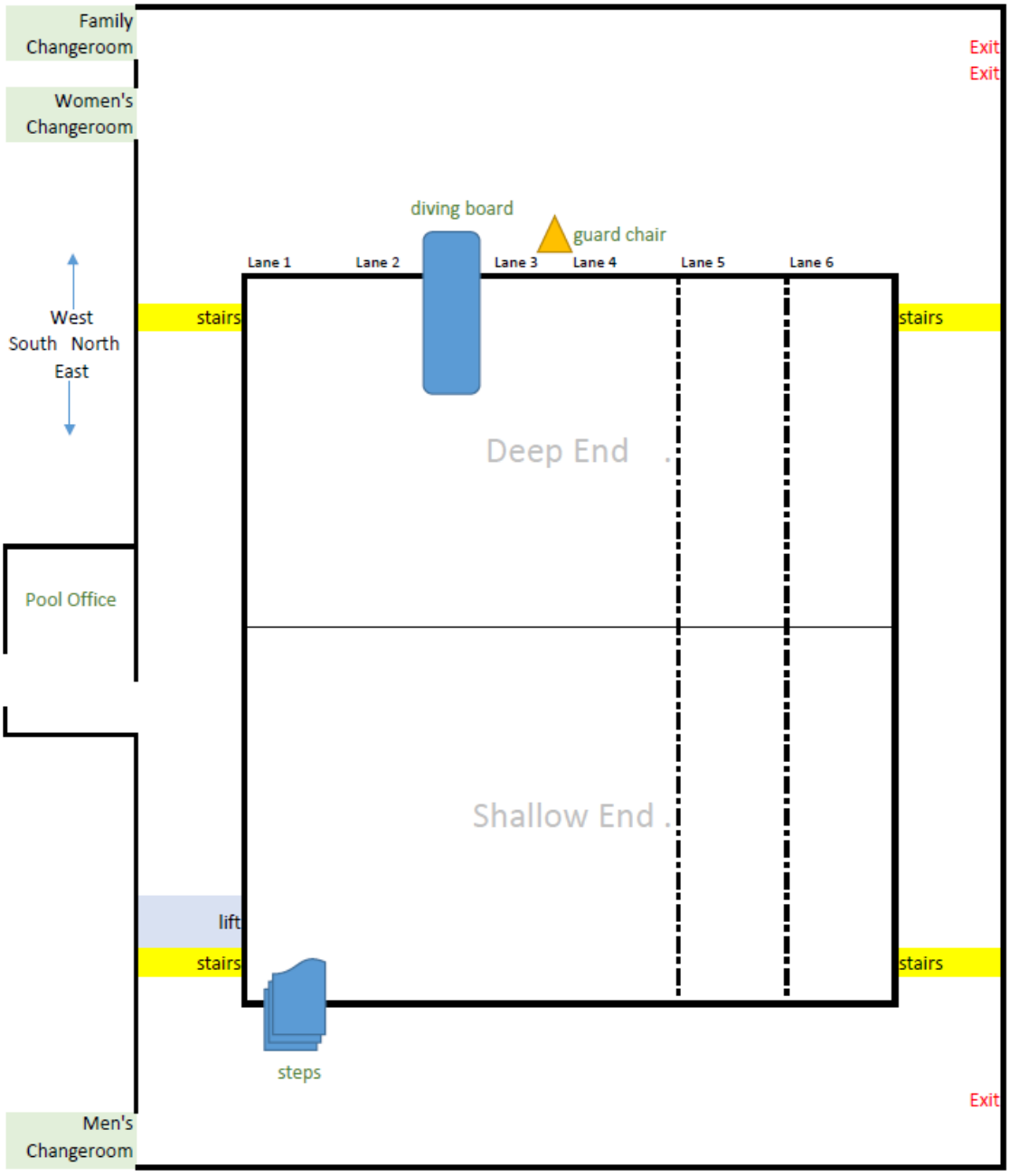
Date Sent:

If yes, please list the next steps that will be taken:

_____
_____
_____
_____

Person completing report:	Position and Title:	Signature:

Pool Deck Layout



Revised: 3/30/2016